

Application for Financial Assistance

Please print clearly in **black ink** for legibility.

Name of applicant: _____

Name of service provider(s): _____

The total of all invoices included in this request is \$ _____

☐ Invoice(s) attached.

I cannot afford to pay all of the attached invoice(s) in full at this time, but I can

pay \$ _____ to _____
(Name of Christian Science practitioner, nurse or facility)

I am requesting assistance in the amount of \$ _____

☐ Please send an e-transfer to the applicant at the following email address:

☐ Please send a cheque to the applicant at the mailing address noted after the signature line of the applicant.

☐ Please pay my service provider directly by e-transfer to the following email address:

☐ Please pay my service provider directly by cheque at the following mailing address:

☐ **I certify that** I am currently relying exclusively on Christian Science treatment.

☐ **I certify that** I have reviewed the attached invoice(s) for services rendered and affirm that all charges are fair and accurate.

☐ **I certify that** no other request for financial assistance relative to the bills covered by this application has been made.

Date: _____

Address: _____

Telephone: _____

Email: _____

If the CSNBF wishes to discuss this application, please contact:

Name: _____

☐ Patient

☐ Power of Attorney for applicant

☐ Relative of the applicant

☐ Caregiver

☐ Christian Science Practitioner

☐ Christian Science Nurse

Telephone: _____

Signature of Patient: _____

After completing this form, please submit by either mail **or** email as outlined below.

Print, sign and mail this Request for Financial Assistance to:

The Treasurer CSNBF
14 Otter Crescent,
Toronto, ON
M5N 2W2

OR

E-mail this Request for Financial Assistance to:

csnbfevaluations@csnbf.ca

[For detailed instructions on mailing or emailing this Request, please see csnbf.ca/apply/]