SickKids | International Patient Program

HERBIE FUND APPLICATION

PATIENT DETAILS

1. Patient Full Name

2. MRN (FOR HOSPITAL STAFF TO ENTER)

FINANCIAL INFORMATION

For each item, enter the monthly amount in CAD and check the box to indicate whether records are being submitted with the application.

INCOME / PROOF OF MONTHLY INCOME	AMOUNT (CAD)	RECORDS SUBMITTED
3. Bank statement (6 months) - required		Yes ☐ No ☐ N/A ☐
4. Employment pay stubs (3 months)		Yes ☐ No ☐ N/A ☐
5. Social assistance		Yes ☐ No ☐ N/A ☐
6. Interest and investment income		Yes ☐ No ☐ N/A ☐
7. Spousal support		Yes ☐ No ☐ N/A ☐
8. Statement of income		Yes ☐ No ☐ N/A ☐
9. Other sources of income		Yes ☐ No ☐ N/A ☐
10. Total Income (monthly)		Yes ☐ No ☐ N/A ☐

EXPENSES / PROOF OF MONTHLY EXPENSES	AMOUNT (CAD)	RECORDS SUBMITTED
11. Housing (rent/mortgage, property tax, other)		Yes ☐ No ☐ N/A ☐
12. Utilities (water, electricity, phone, internet)		Yes ☐ No ☐ N/A ☐
13. Groceries/meals and household supplies		Yes ☐ No ☐ N/A ☐
14. Transportation costs		Yes ☐ No ☐ N/A ☐
15. Health (appointments, medication, dental, vision)		Yes ☐ No ☐ N/A ☐
16. Education (tuition, books)		Yes ☐ No ☐ N/A ☐
17. Other expenses (loans, credit cards)		Yes ☐ No ☐ N/A ☐
18. Total Expenses (monthly)		Yes ☐ No ☐ N/A ☐

19. Briefly state your reason for requesting Humanitarian funding at SickKids (250 words maximum):

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HERBIE FUND APPLICATION

BACKGROUND INFORMATION

Patients approved for Herbie funding are supported by a Herbie Host Family. The Herbie Host Family may be a friend or relative of the patient and family. In other instances, the Herbie Host Family may not previously have any relationship with the patient. The International Patient Program may facilitate matching the applicant with a Herbie Host Family to support the patient and family during the period of care.

20. Do you have a Herbie Host Family?

Yes ☐ (If yes, please provide details below) No ☐

Contact Name

Relationship to Patient

Home Address

City

Province

Country

Postal Code/Zip Code

Home Phone

Mobile Phone

E-mail Address

The following questions help the International Patient Program understand relevant background information and assess arrangements that support a safe and appropriate care experience.

21. Have you ever committed, been arrested for, been charged with, or been convicted of any criminal offence in any country or territory?

Yes ☐ No ☐

22. If you answered "Yes" to question 21, please provide details and supporting documents.

CONFIRMATION OF AGREEMENT

By signing below and submitting the supporting documentation, I hereby certify that all information provided and enclosed is true and accurate, and I agree to the terms set out in this application. I acknowledge that providing false information, falsifying supporting documents or evidence, omitting relevant information, or making false statements in or with respect to the application is grounds for the International Patient Program to deny or rescind the eligibility of my child for care at The Hospital for Sick Children. I agree that upon my child receiving medical clearance from The Hospital for Sick Children medical team, it is expected that we will return to our home country/place of residence abroad.

Applicant Name

Relationship to Patient

Applicant Signature

Date (DD-MM-YYYY)

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