



211 Seton Road • Port Townsend, WA 98368
 360-344-4646 • ECCF@edensaw.com

Edensaw Community Cancer Foundation serves individuals and families in East Jefferson County who are directly affected by the diagnosis of cancer. Applicants applying for assistance through the ECCF may access up to a maximum of \$750.00 per twelve months.

Cancer patients must be within a three month window of treatment (surgery, chemotherapy and / or radiation) and meet the income guidelines as listed. These funds may be used for cancer treatments, rent assistance, public transportation (to and from medical appointments), food and nutritional supplements, COBRA Insurance Premiums, medications not available via pharmaceutical assistance funds, utilities, dental care prior to chemotherapy, childcare as it relates to treatment, medical supplies / treatment and physical therapy.

ECCF funds are also available to help immediate family members living with the cancer patient for uniforms for children sport events, clothing, and medical / pharmaceutical for immediate family member, etc.

Applicants must have their oncology provider fill out the verification of treatment and return this application to ECCF, 211 Seton Road, Port Townsend, WA 98368.

Applications will not be processed without proof of income and assistance is provided on a case by case basis. For more information call (360) 344-4646.

Applicants must meet the following Eligibility Guidelines for ECCF. Proof of income can be established by presenting the following: Statement of benefits for Social Security, Social Security Disability Insurance, Supplemental Security Income, DSHS Cash Assistance, 2014 Income Tax Return or three most recent pay stubs.

Income Eligibility Guidelines for 2016

250% Federal Poverty Level (2016)

Family Size	Monthly Household Income	Annual Household Income
1	2452	29,425
2	3318	39,825
3	4185	50,225
4	5052	60,625
5	5918	71,025
6	6785	81,425
7	7652	91,825
8	8518	102,225

For family size greater than eight, add \$4,160 for each additional member.



Please Print

Name: _____ Date: _____

Address: _____

Telephone: _____ (Applicants must include a contact number)

Diagnosis: _____ Date: _____

Oncologist: _____

Oncologist's Address: _____

Amount Requested: \$ _____

Funds To Be Used For: _____

The fund pays the vendor directly so please provide the necessary information:
(Must provide a statement for requests related to utilities, medical, rental assistance or health insurance premiums. Request for nutrition are provided through a gift card and medication assistance is arranged prior with the pharmacy.)

Vendor: _____

Address: _____

Telephone: _____

Verification of Treatment

Physician: _____

Address: _____

Telephone: _____

Diagnosis: _____ Date: _____

Signature of Physician: _____ Date: _____