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 $1000.00 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, Income Tax Return or three most recent pay stubs.

Income Eligibility Guidelines for 2019

250% Federal Poverty Level (2019)

Family Size	Monthly Household Income	Annual Household Income
1	2602	31,225
2	3522	42,275
3	4443	53,325
4	5364	64,375
5	6285	75,425
6	7206	86,475
7	8127	97,525
8	9047	108,575

For family size greater than eight, add $4,320 for each additional member.

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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: ____

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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: __________________