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 $1,500.00 per twelve months. ECCF funds are available to cancer patients and their immediate family members living with the cancer patient.

Funds may be used to cover the costs associated with cancer treatments, housing, transportation (to and from medical appointments), food and nutritional supplements, COBRA Insurance Premiums, medications not available via pharmaceutical assistance funds, utilities, childcare and medical supplies.

To qualify and receive ECCF support you must:

1. Be within a three-month window of cancer treatment.
2. Meet the income guidelines as listed below.
3. Live within Jefferson County, WA.
4. Submit the application with your treating physician's signature.

Income Table - Eligibility Guidelines		
Family Size	**Monthly Household Income**	**Annual Household Income**
1	$3,038	$36,450
2	$4,108	$49,300
3	$5,179	$62,150
4	$6,250	$75,000
5	$7,321	$87,850
6	$8,392	$100,700
7	$9,463	$113,550
8	$10,533	$126,400

Applicants must meet the Eligibility Guidelines to receive support from the ECCF. Proof of income can be established by submitting the following with your application: Statement of benefits for Social Security, Social Security Disability Insurance, DSHS Cash Assistance, Income Tax Return or three most recent pay stubs. Applications received without proof of income will be approved on a case-by-case basis.

**Applications are typically processed within three weeks of receipt.*

211 Seton Road | Port Townsend, WA 98368 | 360-385-7878 | ECCF@edensaw.com

Edensaw Community Cancer Foundation
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360-385-7878 | eccf@edensaw.com

Applicant Information

Full Name: _____ Date: _____
First *Last* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Diagnosis: _____ Diagnosis Date: _____ Desired Funds: _____

ECCF Funds to be used for: _____

Have you applied for ECCF assistance in the in the past? YES ☐ NO ☐ If yes, when? _____

Are you a resident of Jefferson County, WA? YES ☐ NO ☐ Please submit proof of residence (Driver's License, Bank Statement or Utility Statement with applicant's name and address) with application.

Do you meet ECCF income guidelines? YES ☐ NO ☐ Please submit proof of income (Social Security Statement, Bank Statement, most recent W2, Income Tax Return) with application.

Are you within a three-month window of cancer treatment? YES ☐ NO ☐ If no, explain: _____

Verification of Treatment

To be completed by applicants treating physician or official representative.

Physician: _____ Email: _____

Hospital: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Diagnosis: _____ Date: _____

Physician Signature: _____ Date: _____

Applicant Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____