Funding Request Form

Email completed form to don@cancerkidssjc.org or fax to (209) 333-7569

Patient's Name:		Age:	Disease:		
Parent's Name(s):			Primary Language:		
Mother's Cell:			Father's Cell:		
Home Address:			City, Zip:		Apt. #:
Hospital:			Social Worker:		
SW email:			SW phone:		

Amounts Available to Qualifying Families:

$1,800 ($1,000 min. travel expense) every 6 months while in induction, consolidation, radiation or surgery phase of treatment.

$800 ($500 min. in travel expense every 6 months while patient is in maintenance therapy.

Funding will be distributed in gift cards	**Amount**
Travel Expense – (See above guidelines)	
Gas Gift Cards – (check preference) _____Arco _____Chevron _____Shell	$
Hotels.com	$
Uber	$
Provision Expense	
Safeway	$
Target	$
Travel Meal Expense (Travel Meal Maximum $300)	
Starbucks	$
McDonalds	$
Subway	$
Out of Pocket Expenses necessary to well-being of patient i.e. medical bills, prescription co-pays, auto repair.	
Option #1: Payment will be made directly to health care or service provider.	$
Submit unpaid invoices. Payment will be made directly to care provider.	
Option #2: Payment made to parent or guardian for paid out of pocket expense.	$
Submit copies of paid invoices with proof of payment.	
Total Amount	$

To be signed by parent or guardian at time of receiving gift cards:

Print Name	Relation to child	Signature	Date
_____	_____	_____	_____

Cancer Kids of San Joaquin County A 501(c)(3) non-profit corporation Tax ID 20-4448693 www.cancerkidssjc.org
PO Box 1592
Woodbridge, CA 95258

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