

P.O. Box 1592 Woodbridge, CA 95258

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web: www.cancerkidssjc.org

## Funding Request Form Completed Form May be Emailed, Faxed or Mailed

Patient's Name:	Age:		Disease:	
Parent's Name(s):	Primary Language:			
Mother's Cell:		ſ	Father's Cell:	
Home Address:			City, Zip:	Apt. #:
Hospital:		So	cial Worker:	
SW email:	SW phone:			
Amounts Available to Qualifying Families: \$1,800 every 6 months while in induction, or \$800 every 6 months while patient is in main	ntenance thera	py. (\$500 mi	n. in travel expense).	. in travel expense).
Funding will be distributed in gift cards				<u>Amount</u>
<u>Travel Expense</u>				
Gas Gift Cards – (check preference)	Chevron	Shell	Arco	\$
Hotels.com				\$
Uber				\$
Provision Expense				
Safeway				\$
Target				\$
Travel Meal Expense (Travel Meal Maximu	<u>ım \$300)</u>			
Starbucks				\$
McDonalds				\$ \$
Subway				Ş
Out of Pocket Expenses necessary to well-	-being of patie	nt i.e. medi	cal bills, prescription co-pays, auto	repair.
				4
Option #1: Payment will be made directly				\$
Submit unpaid invoices. Payment will be n	nade directly to	o care provi	der.	
Option #2: Payment made to parent or gu	ardian for paic	out of pock	et expense.	\$
Submit copies of paid invoices with proof of		<u>'</u>	,	
			Total Amount	\$
To be signed by parent or guardian at time o	f receiving gift	cards:		

Signature

Date

Relation to child

**Print Name**