CANCER SUPPORT COMMUNITY SAN FRANCISCO BAY AREA

2022

Emergency Financial Assistance Program

- Cancer Support Community provides emergency financial assistance to low income individuals who are actively in treatment for cancer or will be in active treatment in the next six months. In some situations, the support may be extended to cancer survivors who have completed treatment in the last six months.

- A social worker, doctor, or other medical provider must fill out the intake form, scan it and send it to Zenaida Burgos at zburgos@cancersupport.net. Individuals should be in treatment for cancer in 2022 and have an income level of $30,000 or less as an individual. The request will be reviewed by the CSC East County Program Manager, the Chief Mission Officer and the Finance Manager. Once approved, the check request will be processed and the check will be mailed..

- The check must be made out to an entity such as a landlord, utility, or the funds can be sent via a gift card for groceries. The checks will be mailed to the individual for them to give to the entity that is being paid. The individual whose request is being granted will be mailed a cover letter asking for them to confirm receipt of the check, informing them of the grant and describing the additional services available. This financial support is for the current calendar year. If the need continues, the individual may apply for additional funding in the following calendar year. However, requests from new individuals will have higher priority.

- Assistance can be for rent, utilities, phone, food, medical insurance premiums, non-cosmetic dental & optical, complementary therapies, prescriptions, child care, transportation and nutritional supplements.

- Please note that the applications will be reviewed twice a month and a check will go out within two weeks.

- If the individual has an emergency situation, please speak with Zenaida regarding special arrangements.

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Email to: Zenaida Burgos (Please write clearly)
zburgos@cancersupport.net

Date: _____

Contact Name: _____

Hospital or Medical Provider's Name_____

Email Address: _____ Contact Phone: _____

Please fill out completely. Incomplete information will delay the process.

Patient's Name: _____
Last First

Address: _____
City Zip

Email address:_____

Phone Number: _____ Cancer Type:_____

Date Diagnosed: _____ Date Treatment Started_____

Ethnicity: _____ Age: _____DOB_____

Income Level: _____/mo. Source of Income_____

Insurance: _____ HMO _____ MediCare _____ Medi-Cal

Who should the check be made out to? (Landlord, Utility, Phone, Medical Provider, or would a grocery store gift card be preferred?)

_____Amount Requested: _____

How will funds be used? _____