EASTERN SIERRA CANCER ALLIANCE
Application for Financial Assistance

Help With Money—Help With Resources—Help With Cancer

***ESCA** is dedicated to helping Inyo and Mono County residents dealing with any kind of cancer. We provide **information** about resources available to those dealing with cancer, as well as **financial assistance** for expenses such as medication and tests, travel, clothing, breast prosthesis & bras, mammogram screening, groceries, utility bills, child care, and more.*

For more information about ESCA, please visit our website at www.escanceralliance.org

*All information included on this application is **CONFIDENTIAL***

NAME *(Last, First, Middle Initial):*	**Birth date** *(month/day/year):*
Physical Address:	**City, State:** / **Zip Code:**
Mailing Address:	**City, State:** / **Zip Code:**
Daytime Phone: / Evening Phone:	Message Phone:
Email Address:	

HEALTH / HEALTH INSURANCE INFORMATION

Do you have health insurance? YES / NO	If yes, what kind (Medi-cal, private, Medicare, military, other):
	Physician Name:
	Physician Address:
	Office Phone:

Have you received a diagnosis from your physician? YES / NO

What type of cancer have you been diagnosed with?

What type of treatment will you be receiving?

Chemotherapy YES / NO Radiation Therapy YES / NO Other (please list):

NEEDS

Amount of funding you are requesting:

PLEASE NOTE: If you would like reimbursement for things you have already paid for, please attach copies of receipts (must be dated within the last 30 days) for all items you would like help paying for.

Continue on next page...

How ESCA can help you *(continued…)*

I have read and understand this form. I have provided correct and complete information.

Applicant Signature: Date:

PLEASE RETURN THIS COMPLETED FORM TO:

MAIL:	**DROP OFF:**	**FOR QUESTIONS OR ASSISTANCE**
ESCA P.O. Box 1523 Bishop, CA 93515	Northern Inyo Hospital at the front desk.	Call: 760-872-3811 or come to the resource center at: 2957 Birch Street, Unit 17 Bishop, CA 93514. The resource center is staffed by volunteers. Call first to make sure someone is in the center.

FOR OFFICE USE ONLY

The ESCA Board had determined this applicant to be eligible for assistance.

ESCA Board Chair signature: Date:

The ESCA Board has determined that this applicant is not eligible for assistance.

COMMENTS (i.e., *other resources offered):*

ESCA Board Chair Signature: Date:

Eastern Sierra Cancer Alliance

760.872.3811 | P.O. Box 1523, Bishop, CA 93515

As part of the Eastern Sierra Cancer Alliance Application process, we require your physician's signature and your diagnosis. This form must be updated every 6 months.
Thank you for your cooperation.

Patient's Name	Date

Patient's Diagnosis Under Current Treatment

Physician's Name (please print)

Physician's Signature