Adventist Health Sonora Cancer Patient Support Fund
Support Services Request Form

Through gracious donations from our community we are able to provide resources to patients in need.

*Please indicate the type of services requested by filling out the appropriate sections below. Print this form and bring to the Cancer Institute or mail to: Diana J. White Cancer Institute, 1000 Greenley Road, Sonora, CA 95370

Gas Card: ☐ Date of Request: _____ Date Needed:_____

Patient Name: _____ has requested assistance with transportation with the use of a gas card for the following medical appointments: _____

_____

Please contact me at (phone number): _____ - _____ - _____

This section to be completed and signed when a gas card is provided.

Acknowledgment of Receipt: Amount $_____ Card # _____

Signature: _____ Date: _____
(patient or family representative)

Food Card: ☐ Date of Request: _____ Date Needed:_____

Patient Name: _____ has requested assistance from the support fund for assistance with food/groceries.

Please contact me at (phone number): _____ - _____ - _____

This section to be completed and signed when a food card is provided.

Acknowledgment of Receipt: Amount $_____ Card # _____

Signature: _____ Date: _____
(patient or family representative)

Taxi Voucher: ☐ Date of Request: _____ Date Needed:_____

Patient Name: _____ has requested assistance with transportation with the use of a taxi voucher for _____ on _____.
(reason) *(date/dates)*

Please contact me at (phone number): _____ - _____ - _____

This section to be completed and signed when a taxi voucher is provided.

Acknowledgment of Receipt: Amount $_____

Signature: _____ Date: _____
(patient or family representative)

Financial Assistance: ☐ Date of Request: _____ Date Needed:_____

Patient Name: _____ has requested financial assistance for (please describe the need and the amount) _____.

*Please submit a copy of the financial statement for which you are requesting assistance. This will be used for internal review. The amount of funds distributed is dependent upon the status of the fund and is considered on a case-by-case basis.

Please contact me at (phone number): _____ - _____ - _____

This section to be completed and signed when financial assistance is provided.

Acknowledgment of Receipt: Amount $_____

Signature: _____ Date: _____
(patient or family representative)

Transportation Request: ☐ Date of Request: _____

Patient Name: _____ has requested transportation from _____ to _____ on _____.
(location of appointment) *(date/dates)*

Please contact me at (phone number): _____ - _____ - _____

For Internal Use:

Patient contacted on (date)_____ at (time)_____.

Transportation arranged by _____ with _____.
(staff member name) *(driver name)*

*Please allow 72 hours for your request to be processed.

For internal use:

Staff Signature #1: _____ Date: _____ Time: _____

Staff Signature #2: _____ Date: _____ Time: _____

Notes: _____
_____
_____
_____
_____
_____