Kathleen Sutton FUND

Reimburses transportation costs for women undergoing treatment for cancer, living in Clallam, Jefferson, Kitsap & Mason Counties

Website: www.kathleensutton.org

E-mail: help@kathleensu/on.org

Client Advocates phone #: 360-328-1049

REQUEST FOR REIMBURSEMENT

We appreciate your situation and hope that our resources can help relieve a bit of the financial burden of your diagnosis and treatment.

Our requirements and process are simple:

1. Are you a woman receiving treatment for cancer?

2. Do you live in Kitsap, Clallam, Jefferson or Mason counties of Washington?

3. Are you being treated for cancer?

*There are no further requirements or financial applications required for showing need of financial reimbursement.

-If you can answer yes to these 3 questions, we can start the process.

A KSF Client Advocate can be reached to clarify and answer any questions, at 360-328-1049 or help@kathleensutton.org:

1. A "Request for Reimbursement" form needs to be filled out, signed off by a provider of care: (e.g. social worker, nurse or clinician) and verify the diagnosis/treatment, along with trip information to date the process.

2. We realize that many clients are not aware of, or don't connect with KSF until well into their diagnosis/treatment. We can reimburse transportation expenses retroactively 6 months from confirmation of this process. Any appointments, treatments, procedures that are related to the cancer diagnosis/treatment plan of care.

Please Note: this form must be completed and returned to a KSF Client advocate prior to any funds being dispersed.

-Please Note: This form must be signed/verified by your medical provider/social worker.

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Client Name: _____ Diagnosis:_____

Address: _____

City: _____ Zip: _____

Mailing Address (if different from above):

Address: _____

City:_____ Zip:_____

Phone: _____ Email: _____

I live in the following county:___Clallam ___Jefferson ___ Mason ___Kitsap

Referring Social Worker/ Provider contact info (please print):

Name: _____

Phone: _____

Email: _____

Medical Care Provider Verification: (Please Print Name): _____

I verify that the above patient is receiving care for the diagnosis noted above.

_____ Date:
(Signature of Provider)

****PLEASE SEND COMPLETED FORM TO: help@kathleensutton.org or to the address below**

For questions or more information please call **360-328-1049** to reach our client advocates:

Address: PO Box 727, Kingston, WA 98346
Website: www.kathleensutton.org