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THE TONI ATKINS LESBIAN HEALTH FUND

The Toni Atkins Lesbian Health Fund was established by the Imperial Court de San Diego in conjunction with The San Diego Lesbian, Gay, Bisexual, Transgender Community Center.

Named in honor of San Diego City Councilmember Toni Atkins, the Fund assists low income lesbian and bisexual women in need of medical treatment, referrals, support, education, advocacy and guidance through the healthcare system.

Councilmember Toni Atkins has been active in both the gay & lesbian and women's communities since 1987 when she joined the staff of Womancare Health Center in Hillcrest. As Director of Clinic Services, she helped expand clinic services by acquiring the Los Angeles Feminist Women's Health Center and opening Womencare South Clinic in San Diego's South Bay. Toni worked with The Center's Lesbian Health Project to implement the first Lesbian Health Fair in 1991 as part of the LGBT Pride Festival.

Toni has served as president of the Coalition for Reproductive Choice, co-chair of The Center's Lesbian Health Project, and on the Womancare board of directors. She was recognized in 1997 as San Diego Pride's "Woman of the Year."

Questions or a request for a funding application may be directed to Lea Burgess-Carland at 619-692-2077 x111.



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TONI ATKINS LESBIAN HEALTH FUND APPLICATION FOR FUNDS

Purpose: The Toni Atkins Lesbian Health Fund was established by The Imperial Court de San Diego and The Center to assist low-income and uninsured lesbian and bisexual women in accessing necessary health care resources.

Instructions: Please complete this form and return to Lea Burgess-Carland. You may drop the application off at The Center or mail to P.O. Box 3357, San Diego, CA 92163 attn: Lea Burgess-Carland. For additional information, contact Lea Burgess-Carland at the Women's Resource Center 619.692.2077 ext. 111.

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone (Cell) _____ (Home) _____

Annual Household Gross Income \$ _____

Do you have Health Insurance? YES NO **If YES**, who is your insurer? _____

*Amount of funds requested = \$ _____

*What will the funds be used for?

Signature: _____ **Date:** _____

*Please attach prescription receipts, doctor's invoices and/or quotes, income stub (any kind of income) or any other documentation helpful in assessing your needs.

Please mail or drop off at The Center
Attn: Lea Burgess-Carland.
P.O. Box 3357, San Diego, CA 92163

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