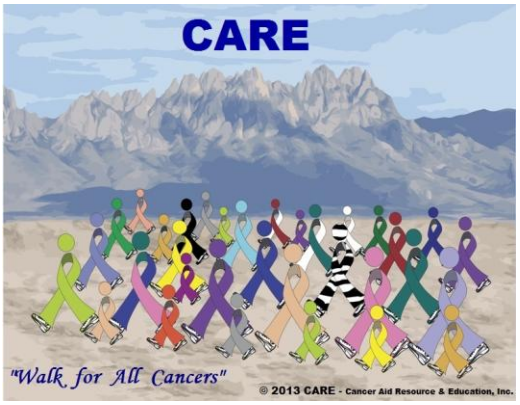


CARE

Cancer Aid Resource &Education, Inc.
141 Roadrunner Parkway, Suite 226
Las Cruces, NM 88011

carelascruces.org
575-680-5922

Proudly Partnered With CAA COMMUNITY ACTION AGENCY OF SOUTHERN NEW MEXICO
High-Impact Programs Building Self-Reliance
3880 Foothills Road, Suite A
Las Cruces, NM 88011
575-527-8799
CARE's Fiscal Sponsor CAASNM is a nonprofit 501(c)(3)
All contributions to CARE are tax deductible
Tax ID # 85-0196070

APPLICATION FOR PATIENT ASSISTANCE
Please Print Application Legibly

This application is your request to Cancer Aid Resource & Education, Inc. (CARE) to consider assistance to any services CARE provides to cancer patients, children and adults, who are receiving treatment for any type of cancer and who reside in Doña Ana County. Unfortunately, submitting an application does not guarantee funds will be available or that your application will be approved. Funds are limited and based on eligibility and availability. We are unable to process incomplete applications. A representative of CARE will contact you upon final review.

Who is Eligible?

In order to be eligible for assistance you must:

1. Be a resident of Doña Ana County and provide proof of residency.
2. Have a diagnosis of cancer as certified by an oncology physician.
3. Currently in **active treatment** for any type of cancer (you are receiving treatment or palliative care).

Meet our financial eligibility guidelines of 500% of the Federal Poverty Limits AND provide proof of income. PLEASE NOTE: All applications will be reviewed. If your income is over the financial guidelines and you have any special circumstances that you feel CARE may consider in your treatment aid, please complete the application and submit to CARE.

Acceptable proof of income include:

Household Size	Gross Family Income	Acceptable Proof of Income
1	$57,450	• **The first two pages of signed copy of income tax return for last two years.** (You may blacken out your social security number) • Copies of your most recent pay stubs for one month's income, unemployment check, or SSI, SSD, or public assistance benefit notification **- OR -** • **If you do not have income:** Provide a letter of support from friend or family member
2	$77,550	
3	$97,650	
4	$117,750	

SECTION 1: Patient Information

(To be completed by Patient or Parent if Patient is a Minor)

Last Name_____ First Name_____

Address _____ City, State, Zip_____

Phone - Home_____ Phone - Cell_____

E-mail_____

( ) Male ( ) Female Age_____ Patient Date of Birth_____

If patient is a minor, name of parent/guardian_____

Ethnicity ( ) White ( ) African American ( ) Hispanic/Latino ( ) Asian ( ) Other_____

1. Have you applied for assistance from CARE before? ( ) YES ( ) NO
   If answer is yes, when did you apply?_____

2. Did you receive assistance? ( ) YES ( ) NO
   If answer is yes, please state Month_____ Year_____ Amount Granted?_____

   Describe the assistance provided by CARE_____

   _____

3. Do you have proof of Dona Ana County residency? ( ) YES ( ) NO
   Acceptable proof is: mortgage receipt, rental payment receipt, utility receipt or voter card.

In the space provided here, please tell us about yourself, your family and the challenges you are currently facing. Please include how and why you would like CARE to help. Attach an additional sheet if necessary.

_____

_____

_____

_____

_____

SECTION 2: Financial Information

A. Family Assets and Income:

1. **ALL APPLICANTS MUST SUBMIT PROOF OF FAMILY ASSETS.**
   To meet this requirement, please submit copies of two current months of bank statements.

2. **ALL APPLICANTS MUST SUBMIT PROOF OF FAMILY INCOME.**
   To meet this requirement, please submit copies of your pay stubs for one month's period of time, any Social Security Administration letters or other documentation detailing financial assistance that you or your family members receive from the government, copies of disability determinations or other sources of income such as food stamps, unemployment, emergency benefits, heating assistance, etc.

1. TOTAL current Monthly Family Income_____
2. Number in household including children_____
3. Please include ages of children under 18_____
4. Currently Employed ( ) YES ( ) NO

B. Income Sources

PLEASE CHECK ALL THAT APPLY AND ATTACH COPIES OF APPROPRIATE DOCUMENTATION

( ) Social Security (Retirement)	**( ) Salary**	**( ) Pension**
( ) Public Assistance	**( ) Short-term disability**	**( ) SSD (Disability)**
( ) Unemployment	**( ) SSI (Supplemental)**	**( ) Child Support**
( ) Sick Leave Pay	**( ) Family/Friends provide support**	**( ) Other**

Specify
Other_____

_____

SECTION 3: Health Insurance Information

1. Do you have health insurance ( ) YES ( ) NO
   If YES, please indicate type of insurance. Check all that apply:

.

( ) Medicaid	( ) Public Health Insurance	( ) Medicare Only
( ) Medicaid Pending	( ) Private Insurance	( ) Medicare plus Medicaid
( ) Emergency Medicaid	( ) VA Program	( ) Charity Care
( ) Medicare plus other supplemental coverage		( ) Indigent Care

1. Are prescription drugs covered? ( ) YES ( ) NO
2. Patient's Co Pays? Provider $_____ Specialist $_____ Prescription $_____

Procedures/Imaging $_____

SECTION 4: List of Assistance Provided by CARE

The following is a list of assistance provided by CARE if funds are available. Please select the top 3 items that CARE may be able to assist with:

( ) Transportation	( ) Medical Supplies	( ) Non Medical Supplies	( ) Wigs
( ) Lymphedema Items	( ) Prostheses	( ) Co Pay Assistance	
( ) Nutritional Supplements	( ) Assistance with Utilities	( ) Other	
Please give specifics:			

SECTION 5: Patient Financial Assistance Needed

Please continue to pay any co pays, medical bills or utilities that you have incurred. The copies of any medical bills or co pays must include: **PROVIDER NAME, PAYMENT ADDRESS, ACCOUNT NUMBER OR SUBSCRIBER ID NUMBER AND ACCOUNT HOLDER (SUBSCRIBER - YOU).**

ITEM	PROVIDER	COMMENTS	AMOUNT REQUESTED ATTACH BILL(S)

SECTION 6: Patient Checklist and Signature of Patient or Guardian Completing This Application

Please verify all sections of this application are complete and attach all documents requested. Incomplete applications will not be considered. To ensure that your application is complete, mark an "X" in each box that applies to your application.

1. ( ) All sections of this application are complete.
2. ( ) Proof of residency (copy of mortgage/rental payment receipt, utility bill or voter card).
3. ( ) First two pages of last two years of federal tax returns (state if federal not filed).
4. ( ) One months of employment pay stubs or one months of proof of income (unemployment, SSI, SSD, etc.).
   If you have no income, provide a letter of support from a friend or family member.
5. ( ) Two months of current bank statements.
6. ( ) If requesting assistance with Section 5, please provide copies of bills/invoices or documentation (co-pay/medical/health, prescription, insurance, termination/shut off utility notices, etc.) for CARE to consider.

CERTIFICATION

I certify that to the best of my knowledge that the information provided in all sections above, is accurate. I understand that funds are limited and based on CARE's availability and eligibility.

I certify that I have read and completed the checklist provided in Section 6 and understand that any missing information will cause my application to be discarded or returned.

Signature of Patient or Guardian_____

Printed Name of Patient or Guardian_____

Date_____

Relationship to person applying for help: ( ) Self ( ) Parent/Guardian/Power of Attorney

CARE INTAKE INFORMATION

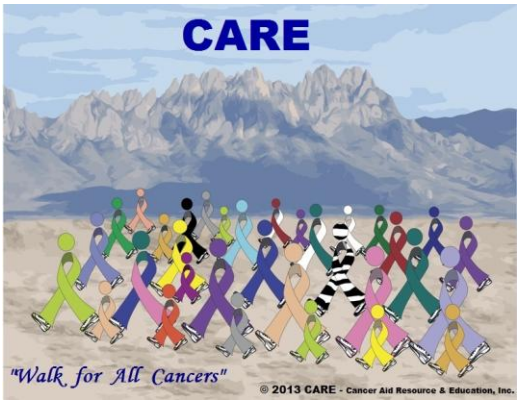
Date Received_____

CARE Board Member-Printed Name & Signature_____

CARE Board Member-Printed Name & Signature_____

CARE Board Member-Printed Name & Signature_____

CARE Board Member-Printed Name & Signature_____



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APPLICATION FOR PATIENT ASSISTANCE

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Must Be Completed By Patient or Patient Representative - Please Print Application Legibly

Patient Name: Last_____ **First**_____ **MI**_____

Patient Address:_____

Patient Date of Birth:_____

I authorize_____**(healthcare provider) to use and disclose the protected health information described below to:**

Cancer Aid Resource & Education, Inc. (CARE)
141 Roadrunner Parkway, Suite 226
Las Cruces, NM 88011

I authorize the following information to be disclosed:

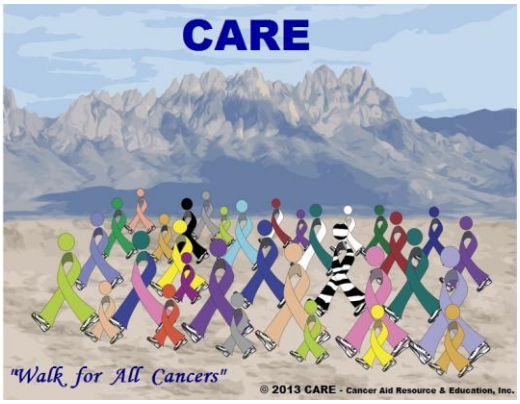
1. **Diagnosis**_____ **Stage**_____
2. **Date of Diagnosis**_____
3. **Treatment Progress (please check): Current**____ **Completed**____ **No Treatment**____

I understand that authorizing the above disclosure is voluntary. I also understand that the purpose of this disclosure is for determination of assistance through CARE. I understand that this authorization is valid for 30 days from signature date. After the date signed, this authorization is subject to revocation at any time except to which the disclosure has already been made by notifying CARE in writing.

PATIENT AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
I certify that I have read the above Authorization to Release Health Care Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ **Date**_____
Signature of Patient or Patient's Representative

_____ _____
Relationship to Patient **Printed Name**



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APPLICATION FOR PATIENT ASSISTANCE

CERTIFIED MEDICAL INFORMATION
MUST BE COMPLETED BY ONCOLOGY PHYSICIAN

Please Print Application Legibly

Patient Name: Last_____ **First**_____ **MI**_____

Patient Date of Birth:_____

Date of Diagnosis _____ Primary Cancer Diagnosis _____

- Stage of Cancer _____ ( ) New Diagnosis ( ) Recurrence
- In active treatment? ( ) YES ( ) NO

If the answer to whether the patient is in active treatment is YES, please indicate type of treatment. Check all that apply:

( ) Chemotherapy	( ) Radiation	( ) Clinical trial	( ) Hormonal	( ) Surgery
( ) Palliative care	( ) Bone Marrow/Stem Cell Transplant		( ) Complementary/Alternative	

If the answer to whether the patient is in active treatment is NO, is post treatment follow-up needed? ( ) YES ( ) NO

If the answer to whether post treatment follow-up is needed is YES, please indicate type of follow-up: ( ) Yearly ( ) Every six months ( ) Other _____

Name of Oncology Physician (please print) _____

MD License #_____ Hospital/Clinic _____

Address _____ City_____

State/Zip _____ Phone ( ) _____Fax ( )_____

Signature of Oncology Physician _____ Date_____

PLEASE NOTE: MUST BE ORIGINAL SIGNATURE - NO STAMPS ALLOWED