CARE

Cancer Aid Resource &Education, Inc.
125 North Main Street, Suite 114
Las Cruces, NM 88001

carelascruces.org
575-649-0598

OFFICE HOURS
Monday thru Thursday
10:00 a.m. to 3:00 p.m.
OFFICE CLOSED
FRIDAYS & HOLIDAYS

OFFICE CLOSED
THANKSGIVING
CHRISTMAS
& NEW YEARS
WEEKS

APPLICATION FOR PATIENT ASSISTANCE

Please Print Application Legibly

This application is your request to Cancer Aid Resource & Education, Inc. (CARE) to consider financial 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. Applications are valid for up to one calendar year, January through December, of the year of the application's submission. If you are receiving treatment beyond the current submission year, you will need to submit a new application per calendar year for any subsequent year(s) you are still in active treatment. We are unable to process incomplete applications. A representative of CARE will contact you upon final review.

CARE's focus is to provide assistance to cancer patients and their families to help them cope with their cancer journey by assisting them with non-medical expenses/basic living needs expenses or emergency funeral expense assistance if they lose their battle.

Who is Eligible?

In order to be eligible for financial assistance you must:
1. Be a resident of Doña Ana County and provide proof of residency and copy of your I.D.
2. Have a diagnosis of cancer as certified by an oncology physician.
3. Currently in **active treatment** (chemotherapy, radiation, surgery, clinical trial or bone marrow/stem cell transplant) for any type of cancer.
4. A child/minor up to the age of 17 who resides in Doña Ana County and is receiving treatment for any type of cancer automatically qualifies for financial assistance.
5. Other Eligibility: If CARE's client loses their battle with cancer, emergency funeral expense assistance may be provided.
6. Meet our financial eligibility guidelines of up to 500% of the Federal Poverty Limits AND provide proof of income. This application must be completed and all requested documents submitted prior to approval.

GUIDELINES:

Household Size	Gross Family Income	Acceptable Proof of Income
1	$57,450	• **The most current Federal Income Tax return. If you don't file a Federal return, please submit a State Income Tax return** (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_____

( ) Male ( ) Female Patient Date of Birth_____ Age_____

Marital Status_____ Spouse Name_____Phone_____

If patient is a minor, name of parent/guardian_____Phone_____

E-mail_____Emergency Contact_____ Phone_____

Cancer Diagnosed_____ ( ) New Diagnosis ( ) Recurrence

Date of Diagnosis_____ Stage_____ Expected Duration of Treatment_____

Are you in active treatment? ( ) Yes ( ) No If yes, please check type of current treatment:
Treatment ( ) Chemotherapy ( ) Radiation ( ) Surgery ( ) Other_____

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 Doña Ana County residency? ( ) YES ( ) NO
   Acceptable proof is: mortgage receipt, rental payment receipt, utility receipt or voter card.
4. Who is your primary care physician/phone number?:_____
5. Who is your oncologist/phone number?:_____
6. How did you learn about CARE?_____

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, etc.

1. TOTAL current Monthly Family Income $_____ Yearly Family Income $_____

MONTHLY INCOME*

INCOME SOURCE	YOU	SPOUSE	OTHER HOUSEHOLD MEMBERS
Wages			
Pension			
Social Security			
Unemployment Benefits			
AFDC/TANF			
Child Support/Alimony			
Food Stamps			
Other			
TOTAL MONTHLY INCOME			

*** Enter gross monthly wages - do not deduct withholding tax or allotments taken out of pay, such as insurance payments, etc.**

2. TOTAL number in household including yourself and children_____ Ages of Children_____
3. Currently Employed ( ) YES ( ) NO Current months income $_____ Last 3 months $_____
4. Do you rent or own your home? ( ) Own ( ) Rent Monthly Mortgage $_____ Monthly Rent $_____
5. Do you have any savings, stocks or property? Savings $_____ Stocks $_____ Property $_____

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	( ) Medicare plus Medicaid	( ) Private Insurance
( ) Medicaid Pending	( ) Medicare Only	( ) Public Health Insurance
( ) 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 – Non Medical Only

The following is a list of assistance provided by CARE. Items involving financial assistance are considered based on eligibility and funds availability. Please select the top 3 items that CARE may be able to assist with:

( ) Transportation (Gas Cards)	( ) Health Insurance Payment	( ) Utilities Assistance
( ) Travel Lodging for Treatment	( ) Support Group/Information	( ) Nutritional Supplements
( ) Food	( ) Rent	( ) Emergency Funeral
( ) Other Consideration – List Item:		Please give specifics on separate sheet if necessary.

SECTION 5: Patient Financial Assistance Needed

Please continue to pay any bills/invoices that have incurred. The copies of any bills/invoices must include: **Vendor Name and Address, Account Holder Name, Date of Bill, Account or Invoice Number, Due Date of Bill and Amount. You will complete a Client Request for Financial Assistance Form for each request of any financial assistance requested.**

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. ( ) Provide photocopy of I.D.
3. ( ) Provide photocopy of insurance card.
4. ( ) Proof of residency (copy of mortgage/rental payment receipt, utility bill or voter card).
5. ( ) Current Federal Tax return (State if Federal not filed).
6. ( ) One months of employment pay stubs or one months of proof of income (employment, unemployment, self employment, SSI, SSD, etc.).

   If you have no income, provide a letter of support from a friend or family member.
7. ( ) Two months of current bank statements.
8. ( ) 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.

Printed Name of Patient or Guardian_____Date_____

Signature of Patient or Guardian_____

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

CARE INTAKE INFORMATION

CARE Representative_____Signature_____Date_____

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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:_____ **Patient Phone:**_____

I authorize any Healthcare Provider or Supplier, Third Party Vendor or Utility Company to use and disclose my protected health information described below or account information to:

Cancer Aid Resource & Education, Inc. (CARE)
125 North Main Street, Suite 114, Las Cruces, NM 88001

I authorize the disclosure of accounts related to and/or submitted with my application, and/or invoices or bills under my name and/or 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 the same period of the application, which is January through December of the year of the application's submission. 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

Your patient has applied for assistance to Cancer Aid Resource & Education, Inc. (CARE). CARE will provide financial assistance based on eligibility and funds availability. Cancer patients' eligibility is based on their being in **active treatment** (chemotherapy, radiation, surgery, clinical trial or bone marrow/stem cell transplant) for any type of cancer. CARE's financial assistance is for non-medical expenses/basic living needs expenses. Your patient will complete a **Client Request for Financial Assistance Form** each time he/she submits a request to CARE for financial assistance. Your patient will request that you sign this form each time to verify that he/she is in active treatment as noted above.

Please Print Application Legibly

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

Patient Date of Birth:_____ **Patient Phone Number:**_____

Address:_____

Date of Diagnosis _____ **Primary Cancer Diagnosis** _____

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

If the answer to whether the patient is in active treatment is YES, please indicate type of treatment method(s) below AND estimated duration of treatment (EDT). Please check all that apply:

( ) Chemotherapy **EDT**_____	( ) Radiation **EDT**_____	( ) Surgery **EDT**_____
( ) Bone Marrow/Stem Cell Transplant **EDT**_____		( ) Clinical trial **EDT**_____

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_____