

CARE

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

CARE USE ONLY:

Date _____
Form # _____
Assistance Today \$ _____
Balance to Assist \$ _____

Client Request for Financial Assistance Form

I, _____, am submitting this request to Cancer Aid Resource & Education, Inc. to request financial assistance. I understand my eligibility for financial assistance is valid for up to one calendar year, January through December, of the current year, based on: (1) my current year's application submission, (2) being in active cancer treatment as described in my approved application, (3) funds availability, (4) eligibility through the CARE policy, (5) up to the cap of assistance and (6) verification I am in active treatment as signed by my oncologist on this form below. The bills I am submitting are not in shut off status nor have they incurred a late fee. **If my bill is on shut off status, I will immediately inform CARE of the need for emergency assistance and request that they notify the vendor that I will be receiving assistance.** I understand that CARE will not pay for any fees or late fees.

I certify that I am currently in active treatment for:

() chemotherapy, () radiation, () surgery, or () bone marrow/stem cell transplant

Client Name _____ DOB _____ Date _____

Address _____

Phone _____ Email _____

1. () The financial assistance I am requesting is assistance with my utility bill(s) or other bill(s) or non-medical basic living expenses that will be paid by CARE to a third party as described below. Attached are original bill(s)/invoice(s)/coupons(s)/document(s) to be paid. I understand that if my bill includes a balance forward, past due or shut-off amount, CARE will fill in amounts (\$) after they verify the balance.

VENDOR (PAYEE)	ACCOUNT HOLDER NAME	DUE DATE OF BILL	ACCOUNT Or INVOICE No.	AMOUNT	CARE VOUCHER #
				\$	
				\$	
				\$	

2. () The financial assistance I am requesting is assistance with a card(s) for the following, check item(s):

() Food \$ _____ CARE VOUCHER # _____ () Gas \$ _____ CARE VOUCHER # _____

3. () The financial assistance I am requesting is assistance with medical travel card/gas and/or lodging or meal expenses for my cancer treatment out of the local area. **Attached** is my appointment letter/prescription/treatment schedule which specifies the days/duration of my treatment (specific days of treatment) as certified by my oncologist, radiologist or surgeon. This is my written request to CARE for financial assistance for applicable non-medical needs expenses during my cancer treatment, which requires me to travel away from home for treatment. Please check items you are requesting financial assistance:

() Medical Travel \$ _____ CARE VOUCHER # _____ Gas \$ _____ CARE VOUCHER # _____

The following is the treatment facility I am traveling to: _____

The following is the scheduled treatment day(s): _____

() Lodging at: _____ Total: \$ _____ CARE VOUCHER # _____

4. () The financial assistance requested is emergency funeral assistance per the policy provided to the cancer patient. Please provide a letter of certification of death from either oncology physician or hospital physician or hospice facility nurse/director.

CARE CLIENT SIGNATURE/GUARDIAN SIGNATURE

DATE

CANCER TREATMENT CENTER – VERIFICATION OF ACTIVE CANCER TREATMENT

Note: Please use blue/colored ink pen: I, Dr. _____, with _____

Cancer Treatment Center certify that my patient _____ is currently in active cancer treatment for: **(circle)**: chemotherapy, radiation, surgery, or a bone marrow/stem cell transplant.

ONCOLOGIST, RADIOLOGIST OR SURGEON SIGNATURE

DATE