CARE USE ONLY:
Date______________________
Form #____________________
Assistance Today $__________
Balance to Assist $__________

CARE

Cancer Aid Resource & Education, Inc.
118 S. Water St., Las Cruces, NM 88001
575-649-0598 – yolidiaz6@msn.com

Client Request for Financial Assistance Form (Form CRFA)

I, ____________________________, am submitting this request to Cancer Aid Resource & Education, Inc. to request financial assistance. I understand my eligibility for financial assistance is valid based on: (1) my approved application, (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 CARE assistance**. I understand that CARE will not pay for any fees or late fees.

I certify that I am currently in active treatment receiving:

( ) chemotherapy, ( ) radiation, ( ) surgery, or ( ) bone marrow/stem cell transplant--(up to 100 days of outpatient care at an out of state medical treatment center where the transplant is performed)

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 ( ):

( ) Food $________ CARE VOUCHER #__________ ( ) Gas $________ CARE VOUCHER #__________

3. ( ) The financial assistance I am requesting is assistance with a 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/hospital physician/hospice physician.

____ ______________________________

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 receiving active cancer treatment for: **(circle)**: chemotherapy, radiation, surgery, or a bone marrow/stem cell transplant.

Note: follow up/maintenance appointments, hormonal treatments, a check-up or testing for cancer are not considered active treatment to our program.

____ ________________________

ONCOLOGIST, RADIOLOGIST OR SURGEON SIGNATURE (Original/No Stamps) DATE