



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 CAASN 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. Be in active treatment for your cancer.

Meet our financial eligibility guidelines of 300% 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	\$34,470	<ul style="list-style-type: none"> • 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 <p style="text-align: center;">- OR -</p> <ul style="list-style-type: none"> • If you do not have income: Provide a letter of support from friend or family member
2	\$46,530	
3	\$58,590	
4	\$70,650	

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 form 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 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:

<input type="checkbox"/> Transportation	<input type="checkbox"/> Medical Supplies	<input type="checkbox"/> Non Medical Supplies	<input type="checkbox"/> Wigs
<input type="checkbox"/> Lymphedema Items	<input type="checkbox"/> Protheses	<input type="checkbox"/> Co Pay Assistance	
<input type="checkbox"/> Nutritional Supplements	<input type="checkbox"/> Assistance with Utilities	<input type="checkbox"/> 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 7: Patient Checklist and Signature of Patient or Guardian

Completing This Application

- 1. () All sections of this application are complete.
- 2. () Attached all documents requested.

CERTIFICATION

I certify that to the best of my knowledge that the information provided in all sections above, excluding Section 6, 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 7 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

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_____



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

carelascruces.org
575-680-5922

Proudly
 Partnered
 With
GAA
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

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:

<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Radiation	<input type="checkbox"/> Clinical trial	<input type="checkbox"/> Hormonal	<input type="checkbox"/> Surgery
<input type="checkbox"/> Palliative care	<input type="checkbox"/> Bone Marrow/Stem Cell Transplant	<input type="checkbox"/> 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