



# CARE

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

[carelascruces.org](http://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"> <li>• The first two pages of signed copy of income tax return for last two years. (You may blacken out your social security number)</li> <li>• Copies of your most recent pay stubs for one month's income, unemployment check, or SSI, SSD, or public assistance benefit notification</li> </ul> <p style="text-align: center;">- OR -</p> <ul style="list-style-type: none"> <li>• If you do not have income: Provide a letter of support from friend or family member</li> </ul>
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 6: 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, 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

**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.

\_\_\_\_\_  
**Signature of Patient or Patient's Representative** Date \_\_\_\_\_

\_\_\_\_\_  
**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:

<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**