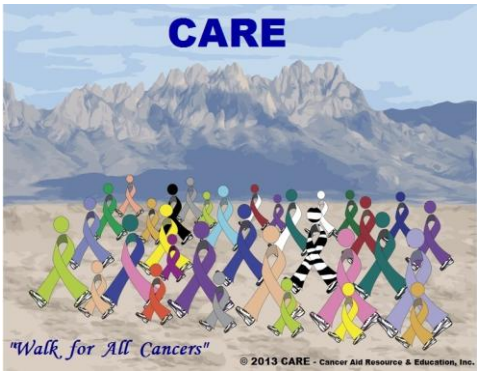


CARE

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

OFFICE HOURS
FOR CLIENTS:
By Appointment

OFFICE CLOSED:
FRIDAYS & HOLIDAYS
THANKSGIVING,
CHRISTMAS &
NEW YEAR WEEKS

APPLICATION FOR PATIENT ASSISTANCE

Please Print Application Legibly

CARE's focus is to provide assistance to cancer patients and their families to help them cope with their cancer treatment by assisting them with non-medical expenses/basic living needs expenses while they are in active treatment for any type of cancer. We realize this is a very difficult time and we hope to do everything possible to make this process go smoothly for cancer patients and their families. This financial assistance is for a person who has recently been diagnosed with any type of cancer and is undergoing active treatment. This is defined as: (1) the period after a positive diagnosis of cancer has been made with a diagnostic biopsy and the Pathology Report coincides with diagnosis date being within one year of application date; and (2) during which therapies to treat their cancer are being administered: receiving chemotherapy, radiation, surgery or a transplant. Eligibility for patients needing a transplant is treatment up to the transplant and the approximate 100 days of outpatient care at an out of state medical treatment center. Active treatment usually may **typically** consist of **one month to up to 12 months**. This is typically the active period CARE may assist cancer patients with financial assistance so that financial stressors are reduced and they concentrate on treatment and recovery and their quality of life and health outcomes are improved. Patients are eligible to receive CARE's financial assistance **up to the cap amount** and for **one time only.**

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 have recently been diagnosed with any type of cancer and who are receiving treatment to eradicate their cancer and who reside in Doña Ana County. Unfortunately, submitting an application does not guarantee funds will be available or that the application will be approved. Funds are limited and based on eligibility and availability. Post treatment follow-up care/follow-up scans, prescribing drugs for maintenance/management/relief of symptoms, indefinite treatment for years beyond the initial diagnosis, a check-up or testing for cancer are not eligible for financial assistance. **We are unable to process incomplete applications**. Upon completion of the application, including requested documents, contact CARE at 575-649-0598 to set up an appointment for submission of the application.

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. Be recently diagnosed with cancer (within one year) as certified by an oncology physician and provide pathology report.
3. Be in current in **active treatment** (receiving chemotherapy, radiation, surgery, or a bone marrow or stem cell transplant-active treatment for transplant is treatment up to the approximate 100 days of outpatient care) 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 dies from cancer, emergency funeral expense assistance may be provided if eligible.
6. Meet our financial eligibility guidelines, including income of up to 400% of the Federal Poverty Limits and provide proof of income and bank statements. This application must be completed and all requested documents submitted prior to approval.

Who is not Eligible? If you were diagnosed beyond one year ago and if you are a patient who is receiving: follow-up care/follow-up scans, prescribed drugs for maintenance/management/long term hormonal therapies, relief of symptoms, indefinite treatment for years beyond the initial diagnosis, a check-up or testing for cancer, this is not considered active treatment for consideration to our program. Thus, this does not meet eligibility for our program.

GUIDELINES:

Household Size	Gross Family Income	Acceptable Proof of Income
1	$48,240	• **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, AFDC, TANF, SNAP or public assistance benefit notification, or • **If you do not have income:** Provide a letter of support from a friend or family member.
2	$64,960	
3	$81,680	
4	$98,400	

SECTION 1: Patient Information

(To be completed by Patient or Parent if Patient is a Minor)

Last Name_____ First Name_____ MI_____

Address _____ City, State, Zip_____

Do you live in: ____City Limits or ____County Do you receive a City of Las Cruces utility bill? Yes/No

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_____

Are you a Veteran? ( ) Yes ( ) No

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?_____
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. Are you employed?: □Full time □Part time □Self-employed □Unemployed □ Disabled □Retired
   If you have your own business, what is the name of your business?_____
5. If you have an employer but are not able to work due to your treatment, can you return to work with your employer after you have recovered? ( ) YES ( ) NO
6. If married, is your spouse/partner employed? ( ) YES ( ) NO
   If answer is yes, type of work_____ Employer_____
7. Have you applied for Social Security Disability? ( ) YES ( ) NO If YES, date?_____
8. Who is your primary care physician/phone number?:_____
9. Who is your oncologist/phone number?:_____
10. 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, checking/savings.

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 cash assistance, food stamps, unemployment, emergency benefits, etc. Please list monthly expenses.

1. TOTAL current Family Income: Monthly Gross $_____ Monthly Net $_____Yearly Gross $_____

MONTHLY INCOME*

INCOME SOURCE	YOU	SPOUSE/OTHERS
Wages		
Pension		
Social Security		
Unemployment Benefits		
AFDC/TANF		
SNAP		
Child Support/Alimony		
Other		
TOTAL MONTHLY INCOME		

MONTHLY EXPENSES:

Home	
Utilities	
Food-Monthly Expense	
Vehicle Payment/Gas	/
Telephone/Cable/Internet	/ /
Health Insurance	
Life Insurance	
Childcare	
Other Expenses	
TOTAL MONTHLY EXPENSES	

*** 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. How many children, including adult children, do you have that live outside of your household? _____
4. Currently Employed ( ) YES ( ) NO Current months income $_____ Last 3 months $_____
5. Do you rent or own your home? ( ) Own ( ) Rent Monthly Mortgage $_____ Monthly Rent $_____
6. Do you have any savings, stocks or property? Savings $_____ Stocks $_____ Property $_____
7. Do you have any type of retirement accounts or life insurance? RET____ERA/ IRA____ 401K___ Life Ins.____

SECTION 3: Health Insurance Information

1. Do you have health insurance ( ) YES ( ) NO Insurance Name _____

If YES, check all that apply below: Case Manager Name_____ Phone_____

( ) Medicaid	( ) Medicare plus Medicaid	( ) Private Insurance
( ) Medicaid Pending	( ) Medicare A( ) B( ) C( ) D( )	( ) 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.		

***Please Note: Travel Lodging for Treatment: You will need to include your appointment letter/prescription/treatment schedule which specifies the duration of your treatment stay as certified by your oncologist for consideration of travel lodging, etc. for financial assistance.**

SECTION 5: Patient Financial Assistance Needed

Please continue to pay any bills/invoices that you have incurred. The copies of any bills/invoices must be **original bills/invoices** and must include: **Your Name, Vendor Name and Address, Account Holder Name, Date of Bill/Invoice, 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 and your oncologist will also sign the form. **You will also need to set up an appointment to provide the bill(s) and sign voucher(s).**

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 a copy of your pathology report.
3. ( ) Provide photocopy of I.D.
4. ( ) Provide photocopy of insurance card(s).
5. ( ) Proof of residency (copy of mortgage/rental payment receipt, utility bill or voter card).
6. ( ) Please provide copy of water bill.
7. ( ) Current Federal Tax return (State if Federal not filed).
8. ( ) One months of employment pay stubs or one months of proof of income for everyone in your household (employment, unemployment, self employment, SSI, SSD, AFDC, TANF, SNAP, etc.).
   If you have no income, provide a letter of support from a friend or family member.
9. ( ) Two months of current bank statements.

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.

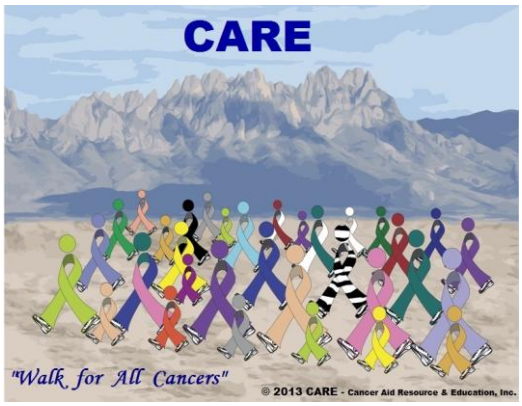
Printed Name of Patient or Guardian_____Date_____

Signature of Patient or Guardian_____

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

CARE INTAKE INFORMATION

CARE Representative_____Signature_____Date_____



CARE

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carelascruces.org
575-649-0598 - Email: yolidiaz6@msn.com

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 for utility accounts or any non-medical accounts 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:

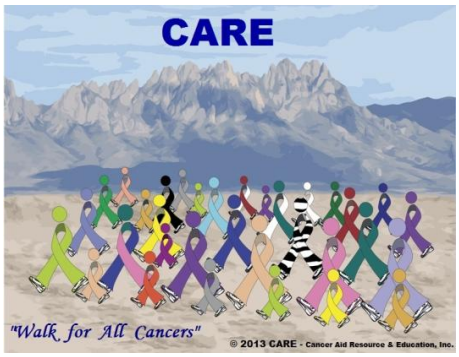
1. **Diagnosis**_____ **Stage**_____
2. **Date of Diagnosis**_____
3. **Treatment Progress (please check): Current**_____ **Completed**_____ **No Treatment**_____

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'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**



CARE

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APPLICATION FOR PATIENT ASSISTANCE

CERTIFIED MEDICAL INFORMATION
MUST BE COMPLETED BY ONCOLOGY PHYSICIAN

Your patient has applied for financial 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: (1) the period after a positive diagnosis of cancer has been made with a diagnostic biopsy and the Pathology Report coincides with the diagnosis date being within one year of application date; and (2) during which therapies to treat their cancer are being administered: receiving chemotherapy, radiation, surgery or a transplant. Eligibility for patients needing a transplant is treatment up to the transplant and the approximate 100 days of outpatient care at an out of state medical treatment center. Active treatment usually may **typically** consist of **one month to up to 12 months**. This is typically the active period CARE may assist cancer patients and their families with financial assistance so that financial stressors are reduced and they concentrate on treatment and recovery and their quality of life and health outcomes are improved. Patients are eligible to receive CARE's financial assistance **up to the cap amount** and for **one time only.**

CARE's financial assistance is for non-medical expenses/basic living needs expenses only. 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 NOTE: Who is not Eligible? **If you are providing treatment to a patient who is receiving: follow-up care/follow-up scans, prescribing drugs for maintenance/management/long term hormonal therapies/relief of symptoms, indefinite treatment for years beyond the initial diagnosis, a check-up or testing for cancer, a clinical trial, this is not considered active treatment for consideration to our program. Thus, this does not meet eligibility for our program and checking "No" for active treatment applies.**

Please Print Application Legibly – Please Complete Sections Legibly

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

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

Address:_____

Date of Diagnosis _____ **Cancer Diagnosis** _____

- **Stage of Cancer** _____ **( ) New Diagnosis ( ) Recurrence ( ) Follow-up/Maintenance Care**
- **In active treatment? ( ) YES ( ) NO IF YES, PROVIDE ANSWER(S) BELOW**
- **Please attach copy of pathology report. Date of pathology report's diagnosis**_____

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 **Estimated Duration of Treatment**_____	( ) Radiation **Estimated Duration of Treatment**_____
( ) Surgery **Estimated Duration of Treatment**_____	( ) Bone Marrow _____ or Stem Cell Transplant _____ **Estimated Duration of Treatment**_____

Name of Oncology Physician (please print) _____

MD License #_____ Hospital/Clinic _____

Address _____ City_____

State/Zip _____ Phone ( ) _____ Fax ( )_____

Signature of Oncology Physician _____ Date_____