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 (Form APA)

Please Read Application in Its Entirety. Print Application Legibly. Initial ____ at End of Each Paragraph

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 the out of state medical treatment center where the transplant was performed. 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 application only.** Please initial that you have read and understood each paragraph on this page. ☐

This application is your request to Cancer Aid Resource & Education, Inc. (CARE) to consider financial assistance CARE provides to cancer patients, children and adults, who have recently been diagnosed with any type of cancer and who are receiving treatment to treat 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/long term hormonal therapies/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 review/consideration. We encourage you to bring a family member or caregiver with you; we encourage you to not attend this appointment alone. ☐

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 a copy of your valid 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 **active treatment: receiving** chemotherapy, radiation, surgery, or a bone marrow or stem cell transplant (active treatment for a 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/or if you are a patient who is receiving: follow-up care/follow-up scans, prescribed drugs for maintenance/management/long term hormonal therapies, beyond the 100 days of a transplant, 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?_____
2. Did you receive assistance? ( ) YES ( ) NO
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
   Who is your employer or what is the name of your business?_____
5. If you have an employer, but are not able to work due to your treatment: (1) Do you have a sick leave policy?
   ( ) YES Hrs:_____ ( ) NO (2) Can you return to work with your employer after you have recovered? ( ) YES ( ) NO
6. If married, is your spouse/partner employed? ( ) YES ( ) NO Employer_____
7. Do you receive Medicaid? ( ) YES ( ) NO 8. Do you receive Medicare? ( ) YES ( ) NO
9. Are you currently receiving income/food/housing/mileage assistance from other agencies? ( ) YES ( ) NO
   If answer is yes, Name of Agency(s)_____
10. Have you applied for Social Security Disability? ( ) YES ( ) NO If YES, date?_____
11. Who is your primary care physician/phone number?:_____
12. Who is your oncologist/phone number?:_____
13. How did you learn about CARE?_____
14. Please tell us about yourself. Please attach a letter of the challenges, you and your family, are currently facing. Please include how and why you would like CARE to help.

SECTION 2: 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.	

SECTION 3: 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		

MONTHLY EXPENSES:

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

*** 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? Retirement___ERA/ IRA__ 401K__ Life Ins.___

SECTION 4: 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 $____

PATIENT CHECKLIST – CERTIFICATION – SIGNATURE

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, please mark an "X" below:

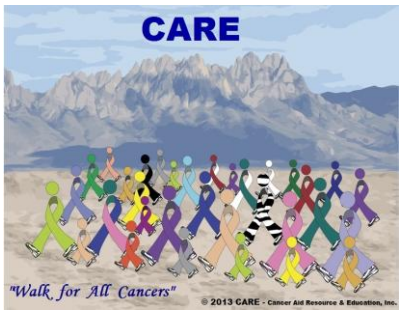
. Please provide a copy of your: ( ) Pathology Report ( ) Valid ID ( ) Insurance card(s)
( ) Proof of residency in Doña Ana County (copy of mortgage/rental payment receipt, utility bill or voter card).
( ) Water or gas bill ( ) Federal Tax return ( ) One months of employment pay stubs or one months of proof of income for everyone in your household (employment, unemployment, self employment, SSI, SSD, AFDC, TANF, SNAP, etc.) If no income, letter of support. ( ) Provide two months of your 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 & Signature of Patient or Guardian_____**Date**_____

CARE Representative_____Signature_____Date_____



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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 the out of state medical treatment center where the transplant was performed. 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 if they are: **receiving active treatment** as described on (2) above, **up to the cap amount** and for **one application 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/beyond the 100 days of a transplant, 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_____