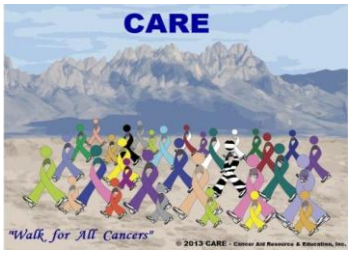

CARE
Cancer Aid Resource & Education Inc.
118 S. Water St.
Las Cruces, NM 88001
carelascruces.org
575-649-0598
Email: yolidiaz6@msn.com

Office Hours for Patients:
By Appointment Only

Office Closed:
Fridays, Holidays, Thanksgiving, Christmas and 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 who reside in Doña Ana County to help them cope with their cancer treatment by assisting them with non-medical/basic living needs expenses while they are in active treatment for any type of cancer.

This is defined as:
(1) A positive diagnosis of cancer made with a diagnostic biopsy and Pathology Report confirming diagnosis date within one year of application date for any type of cancer in children and adults.
(2) Currently receiving treatment therapies to cure, shrink or stop the progression of their cancer: such as, chemotherapy, radiation, surgery or a transplant. For patients needing a transplant, eligibility includes treatment up to the transplant and approximately 100 days of outpatient care where the transplant was performed. CARE assists cancer patients during active treatment in order to reduce financial stress, allowing the patient to concentrate on treatment and recovery to improve health outcomes and quality of life**. Eligible patients receive CARE's financial assistance up to the cap amount and for one application only.** ☐

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. CARE assistance generally helps over a 6 month period, as treatment ensues.

Upon completion of this application, including supporting documentation, **contact CARE at 575-649-0598** to schedule an appointment for review of application and potential approval. We encourage you to bring a family member or caregiver with you and not attend this appointment alone. **We are unable to process incomplete applications**. ☐

Summary of Eligibility Requirements:

1. Be a resident of Doña Ana County; 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. 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.

INCOME 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** (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 friend or family member.
2	$64,960	
3	$81,680	
4	$98,400	

SECTION 1: Patient Information

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

PERSONAL INFORMATION

Last Name_____First Name_____MI_____
Address_____City, State, Zip_____

Is your address _____Las Cruces City Limits or _____Doña Ana County

Do you receive a City of Las Cruces utility bill? ( ) Yes ( ) No

Do you have proof of Doña Ana County residency? ( ) Yes ( ) No

Acceptable proof is: mortgage receipt, rental payment receipt, utility receipt or voter card

Phone - Home_____Phone - Cell_____
Patient Date of Birth_____Age_____ Sex: ( ) Male ( ) Female
Marital Status: ( ) Single ( ) Divorced ( ) Widow/Widower ( ) Separated
If married: Spouse Name_____Phone_____
If patient is a minor: Name of parent/guardian_____Phone_____
Level of education: ( ) Did not graduate high school ( ) HS Graduate ( ) College Graduate ( ) Post Grad degree
E-mail_____Emergency Contact_____Phone_____
Ethnicity: ( ) White ( ) African American ( ) Hispanic/Latino ( ) Asian ( ) Other_____
Are you a Veteran? ( ) Yes ( ) No
Have you applied for assistance from CARE before? ( ) Yes ( ) No If answer is yes, when?_____
Did you receive assistance? ( ) Yes ( ) No

MEDICAL INFORMATION

Type of Cancer Diagnosed_____ ( ) New Diagnosis ( ) Recurrence

Date of Diagnosis_____Stage_____Expected Duration of Treatment_____

Primary care physician/phone number:_____

Oncologist/phone number:_____

Are you in active treatment? ( ) Yes ( ) No

If yes, check type of current treatment: ( )Chemotherapy ( )Radiation ( ) Surgery ( )Other_____

INCOME INFORMATION

Employment Status: ( ) Full time ( ) Part time ( ) Self-employed ( ) Unemployed ( ) Disabled ( ) Retired
If employed, name of employer or name of your business:_____

If employed, but are unable to work due to your treatment: Do you have a sick leave policy? ( ) Yes Hrs:____ ( ) No

Can you return to work with your employer after you have recovered? ( ) Yes ( ) No

If married, is your spouse/partner employed? ( ) No ( )Yes Employer_____

Do you receive Medicaid? ( ) YES ( ) NO Do you receive Medicare? ( ) Yes ( ) No

Are you currently receiving income/food/housing/mileage assistance from other agencies? ( ) Yes ( ) No
If yes: Name of Agency(s)_____

Have you applied for Social Security Disability? ( ) No ( ) Yes If YES, date?_____

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 and how you learned about CARE.

Please acknowledge that you will complete a Patient Request for Financial Assistance with each request. ☐

SECTION 2: List of Assistance Provided by CARE – Non-Medical Only

Following is a list of assistance provided by CARE. Please select the top 3 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.

Please submit copies of two current months of bank statements: checking/savings.

2. ALL APPLICANTS MUST SUBMIT PROOF OF FAMILY INCOME.

Please submit copies of your pay stubs for one month's period of time, any Social Security Administration letters or other documentation of 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.

Monthly Net $_____ Yearly Gross $_____

GROSS MONTHLY INCOME*

Income Source	You	Spouse/Others
Wages		
Pension		
Social Security		
Unemployment benefits		
AFDC/TANF		
SNAP		
Child Support/Alimony		
Other		
Total		

MONTHLY EXPENSES

Home (rent or mortgage)	
Utilities	
Food	
Vehicle Payment/Gas	/
Phone/Cable/Internet	/ /
Health Insurance	
Life Insurance	
Childcare	
Other expenses	
Total	

***Enter gross monthly wages - do not deduct withholding tax or allotments taken out of pay, such as insurance payments, etc.**

1. TOTAL number in household including yourself and children_____ Ages of Children_____
2. How many children, including adult children, do you have that live outside of your household? _____
3. Do you have any savings, stocks or property? Savings $_____ Stocks $_____ Property $_____
4. Retirement accounts or life insurance: ( ) Retirement ( ) ERA/ IRA ( ) 401K ( ) Life Insurance

SECTION 4: Health Insurance Information

Do you have health insurance ( ) YES ( ) NO Insurance Company 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

Are prescription drugs covered? ( ) Yes ( ) No

Patient's Co Pays: Provider $_____ Specialist $_____

PATIENT CHECKLIST – CERTIFICATION – SIGNATURE

Please verify all sections of this application are completed and attach all documents requested. To ensure that your application is complete, please use this checklist to confirm your application is complete.

Incomplete applications will not be considered.

Please provide a copy of your:

( ) Completed Application for Patient Assistance form
( ) Oncologist signed Patient Request for Financial Assistance form
( ) Oncologist signed Certified Medical Information form
( ) 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 month of employment pay stubs or one month of proof of income for everyone in your household (employment, unemployment, self-employment, SSI, SSD, AFDC, TANF, SNAP, etc.)
( ) If no income, provide 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 fund availability and my eligibility. I understand that the goal of the program is to assist me while I am receiving treatment therapies to cure, shrink or stop the progression of my cancer (kill cancer cells or shrink tumors): chemotherapy, radiation, surgery or a transplant. I understand that I am not eligible for assistance if I am on any follow up or maintenance care, treatment years beyond the initial diagnosis, long term therapies or reconstruction/cosmetic care. I certify that I have read and completed the checklist provided above 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_____