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

CARE USE ONLY:
Date_____
Form# _____
Assistance Today $_____
Balance to Assist $_____

PATIENT REQUEST FOR FINANCIAL ASSISTANCE FORM (Form PRFA)

I, _____, Date of Birth _____, am submitting this request to CARE for financial assistance. I understand my eligibility for financial assistance is valid based on CARE eligibility criteria and verified by my oncologist's signature below. The bills I am submitting are not in shut off status nor have they incurred a late fee. I understand that I must submit original bills/invoices/coupons to process payments. (In case of emergency, contact CARE directly.)

I certify that I am currently receiving: ( ) chemotherapy, ( ) radiation, ( ) surgery, or ( ) bone marrow/stem cell transplant—(within 100 days of outpatient care where the transplant was performed) to cure, shrink or stop the progression of my cancer.

I. Requests for Bill Payments

1. ( ) I am requesting assistance with my utility bill(s) or other bill(s) for non-medical basic living expenses to be paid by CARE to a third party. Attached are **original** documents to be paid. If my bill includes an unpaid balance, past-due or shut off amount, CARE will fill in dollar amounts after verifying the balance.

VENDOR (PAYEE)	ACCOUNT HOLDER NAME	DUE DATE OF BILL	ACCOUNT or INVOICE #	AMOUNT	CARE VOUCHER #

II. All Other Requests

1. ( ) I am requesting card(s) for the following (check item only). CARE provides amount per policy.
( ) Food $_____ CARE Voucher #_____ ( ) Gas $_____ CARE Voucher #_____

2. ( ) I am requesting medical travel card(s) and/or lodging, meals for my prescribed treatment outside the local area. Attached is the documentation that supports my treatment plan as certified by my physician's signature below. (Please check items requesting.)
( ) Medical Travel $_____ CARE Voucher # _____ ( ) Gas $_____ CARE Voucher #_____
( ) Lodging at:_____ Total $_____ CARE Voucher #_____

_____ _____
PATIENT SIGNATURE/GUARDIAN SIGNATURE DATE

CANCER TREATMENT CENTER - CERTIFICATION OF ACTIVE TREATMENT

Note: Please use blue colored ink pen

I, Dr._____, with_____
Cancer Treatment Center certify that my patient_____ is currently receiving active cancer treatment with ( ) chemotherapy ( ) radiation ( ) surgery ( ) bone marrow/stem cell transplant)

_____ _____
ONCOLOGIST, RADIOLOGIST or SURGEON SIGNATURE (Original/No Stamps) DATE

Note: Follow up/maintenance appointments, hormonal therapy, check-up or testing for cancer are not considered active treatment to CARE.