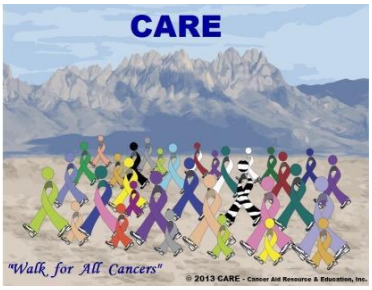

CARE
Cancer Aid Resource & Education, Inc.
118 S. Water Street
Las Cruces, NM 88001
carelascruces.org
575-649-0598
Email: yolidiaz6@msn.com

APPLICATION FOR PATIENT ASSISTANCE – PHYSICIAN FORM

PHYSICIAN CERTIFICATON OF ACTIVE TREATMENT

(MUST BE COMPLETED BY ONCOLOGIST, RADIOLOGIST or SURGEON)

Your patient has applied for financial aid from CARE. CARE provides financial aid based on patient eligibility and funds availability for non-medical expenses only. Your patients' eligibility is based on:
(1) a positive diagnosis of cancer made with a diagnostic biopsy and Pathology Report verifies that the diagnosis date is within one year of the application date; and
(2) active therapies to cure, shrink or stop the progression of their cancer are ongoing: chemotherapy, radiation, surgery or a transplant. (Transplant eligibility is treatment from transplant and ~ 100 days of outpatient care where the transplant was performed.)

Your patient will complete a **Patient Request for Financial Assistance Form** each time he/she submits a request to CARE for financial assistance. You must sign this form each time to verify that he/she is in active treatment as noted above.

PLEASE NOTE: The following activities are not within the scope of CARE's aid: 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 or reconstruction/cosmetic care. Such patients do not meet eligibility for our program and checking "No" for active treatment applies.

Physician Certification of Active Treatment - Please Print 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**_____

( ) Chemotherapy **Estimated Duration of Treatment**_____	( ) Radiation **Estimated Duration of Treatment**_____
( ) Surgery **Estimated Duration of Treatment**_____	( ) Bone Marrow ( ) 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_____