CARE

Cancer Aid Resource & Education Inc.
118 S. Water Street
Las Cruces, NM 88001
575-652-5407 or 575-649-0598
Website: carelascruces.org
Email: caresupportprogram@carelascruces.org

Office Hours for Patients:
By Appointment Only

Office Closed:
Fridays
Holidays
Thanksgiving, Christmas and New Year Weeks

APPLICATION FOR PATIENT FINANCIAL ASSISTANCE (Form APFA)

Please Read Application & Complete in Its Entirety. Print Application Legibly. Initial ☐ at End of Each Paragraph

CARE's focus is to provide assistance to cancer patients, children and adults, and their families who reside in Doña Ana County to help them cope with their cancer treatment and reduce their financial stress. CARE intervenes on the financial toxicity of cancer by providing financial support for basic living needs to people who reside in Doña Ana County recently diagnosed with any type of cancer and in treatment to cure, shrink or stop the progression of their cancer, so they may focus on treatment, healing and recovery. CARE's goal is to be part of the solution to improve health outcomes and cancer survivorship. CARE is here to help; both CARE volunteers and patients will follow CARE policies and procedures to best serve all cancer patients.

The following applies:
(1) A positive diagnosis of cancer made with a diagnostic biopsy and Pathology Report confirming diagnosis date within six months of application date for any type of cancer.
(2) Currently receiving treatment therapies: 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 is performed.
Eligible patients receive CARE's financial assistance up to the cap amount as long as they are in treatment. Eligible patients may only submit one application in a lifetime. Circumstances may be unique; therefore CARE may consider applications by each unique case. ☐

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 3 to 6 month period, based on what each patient chooses benefits them most and as treatment continues. Upon completion of this application, including supporting documentation, **please contact CARE at above phone number(s) to schedule an appointment** for review of application and potential approval. We encourage you to bring a family member or caregiver or someone with you who cares about you and your needs during your cancer treatment that can help you while you are in our program. **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 six months) 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; application submission applies.
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	$49,960	✓ **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 a friend or family member.**
2	$67,640	
3	$85,320	
4	$103,000	

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 bill/receipt or voter card

Phone - Home_____ Phone - Cell_____

Patient Date of Birth_____ Age_____ Sex: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow/Widower ( ) Separated

If married: Spouse Name_____ Phone_____

If patient is a minor: Name of parent/guardian_____ Phone_____

Family Advocate/Caregiver Name:_____ Phone_____

Level of education: ( ) Did not graduate high school ( ) HS Graduate ( ) College Graduate ( ) Post Grad degree

Patient E-mail_____ Emergency Contact_____ Phone_____

Race: ( ) White ( ) Black or African American ( ) American Indian ( ) Asian ( ) Native Hawaiian or Pacific Islander

Ethnicity: Hispanic or Latino_____ Non-Hispanic or Latino_____ Are you a Veteran? ( ) Yes ( ) No

Have you received assistance from CARE before? ( ) Yes ( ) No If answer is yes, when?_____

MEDICAL INFORMATION

Type of Cancer Diagnosed_____ ( ) New Diagnosis ( ) Recurrence

Date of Diagnosis_____ Stage_____ Expected Duration of Treatment_____

Primary care physician/phone number:_____

Treatment Center_____ 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:_____

Are you the primary income earner? ( ) Yes ( ) No Are you receiving short-term disability through work? ( ) Yes ( ) No

Are you paid as a salaried employee? ( ) Yes-Yearly $_____ ( ) No Are you paid hourly? ( ) Yes, Rate $_____ ( ) No

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

Are you still receiving a salary? ( ) Yes ( ) No Can you return to work with your employer after your treatment? ( ) Yes ( ) No

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

Are you in a one-income household? ( ) Yes ( ) No

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

Do you receive Social Security Disability (SSD)? ( ) Yes ( ) No Have you applied for SSD? ( ) Yes ( ) No

Are you currently receiving income/food/housing/mileage assistance from other agencies? ( ) Yes ( ) No

If yes: Name of Agency(s)_____

Please attach a letter of the challenges, you and your family, are currently facing and how CARE can help.

How did you learn about CARE:_____

Please acknowledge that you will complete a Patient Request for Financial Assistance Form at each visit, at each request that you schedule to have any bills paid or any gas, food or medical travel cards issued. ☐

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)	( ) Food/Nutritional Supplements	( ) Health Insurance – Self Pay
( ) Utilities	( ) Phone Payment	( ) Rent
( ) Mortgage	( ) Medical Travel Lodging	( ) Medical Travel Card
( ) Fitness/Gym Membership	( ) Other Consideration – Item: Please provide request in writing for consideration.	

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: both checking and savings accounts.

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.

YEARLY GROSS $_____

MONTHLY INCOME

HOUSEHOLD INCOME	Monthly Amount Before Diagnosis	Monthly Amount Current
Your wages/salary if you are currently working (before taxes)		
Spouse/partner's wages/salary (before taxes)		
Other income of you and your spouse/partner combined (before taxes)		
Income from other contributing household members (before taxes)		
TOTAL HOUSEHOLD GROSS INCOME	**$**	**$**
Your wages/salary if you are currently working (after taxes)		
Spouse/partner's wages/salary (after taxes)		
Income from other contributing household members (after taxes)		
Pension		
Social Security (SSI/SSD)		
Disability		
Unemployment benefits		
AFDC/TANF/SNAP		
Child Support/Alimony		
Business/Self Employment/Rental income		
Other Income – List type of support		
TOTAL HOUSEHOLD NET INCOME	**$**	**$**

MONTHLY EXPENSES

HOUSEHOLD EXPENSES	Monthly Amount Before Diagnosis	Monthly Amount Current
Home: Mortgage☐ Rent☐		
Utilities (electricity, gas, water, trash, sewage)		
Food		
Vehicle Payment/Gas: Vehicle $ Monthly Gas $ Total →		
Phone/Cable/Internet: Phone $ Cable $ Internet $ Total →		
Self Pay Health Insurance		
Life Insurance		
Childcare		
Household Items/Non Food Items		
Other Expenses		
Medications related to cancer treatment only		
Medical co-payments and/or share of cost of cancer treatment		
TOTAL HOUSEHOLD EXPENSES	**$**	**$**

1. Why has your income or expenses changed during treatment?_____
_____
2. Do you have other health conditions that you purchase medication for? ( ) Yes, Monthly cost $_____ ( ) No
3. TOTAL number in household?:_____ How many are children?_____Ages of Children_____
4. How many children, including adult children, do you have that live outside of your household? _____
5. How much do you have in savings, stocks or property? Savings $_____Stocks $_____Property $_____
6. Do you have Retirement/Life Insurance?: ( ) Retirement ( ) ERA/ IRA ( ) 401K ( ) Life Insurance ( ) None

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
( ) NM Medical Insurance Pool	( ) VA Program	( ) Indigent Care
( ) Medicare plus other Supplemental Coverage		( ) Affordable Care Act/Marketplace

Prescription Costs: Tier 1 $_____ Tier 2 $_____ Tier 3 $_____ Tier 4 $_____ $0 prescription cost_____
Maximum Yearly Out of Pocket Cost: $_____
Medical Cost Share/Co Pays: Primary Care $____ Specialist Visits $____ Urgent Care $____ $0 Medical costs___

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.**

Forms to complete are underlined. Please mark each item below that you are providing a copy of your:

1. ( ) Application for Patient Financial Assistance (this 4-page form is completed and signed by patient)
2. ( ) Application for Patient Financial Assistance – Physician Form (form is completed and signed by physician)
3. ( ) Patient Request for Financial Assistance Form (patient and physician complete and sign form)
4. ( ) Pathology Report
5. ( ) Valid ID
6. ( ) Insurance card(s)
7. ( ) Proof of residency in Doña Ana County (copy of mortgage/rental payment receipt, utility bill or voter card)
8. ( ) Water or gas bill
9. ( ) Federal Tax return (State Tax Return if you don't file federal taxes)
10. ( ) 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.)

Or ( ) If no income, please provide letter of support.

11. ( ) Provide two months of your current bank statements – checking and savings

CERTIFICATION

I certify that to the best of my knowledge that the information provided in all sections above is true and 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 or hormonal 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. By signing below, I also agree that I will adhere to the stated CARE policies and procedures.

Printed Name of Patient or Guardian	**Signature**	**Date**
CARE Patient Advocate	**Signature**	**Date**