



CARE

Cancer Aid Resource & Education Inc.

118 S. Water Street

Las Cruces, NM 88001

carelascruces.org

575-652-5407 or 575-649-0598

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

E-mail _____ Emergency Contact _____ Phone _____

Race: () White () African American () Hispanic/Latino () American Indian () Asian () Other _____

Are you a Veteran? () Yes () No

Have you applied for 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: _____

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

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 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:

<input type="checkbox"/> Transportation (Gas Cards)	<input type="checkbox"/> Food/Nutritional Supplements	<input type="checkbox"/> Health Insurance – Self Pay
<input type="checkbox"/> Utilities	<input type="checkbox"/> Phone Payment	<input type="checkbox"/> Rent
<input type="checkbox"/> Mortgage	<input type="checkbox"/> Medical Travel Lodging	<input type="checkbox"/> Medical Travel Card
<input type="checkbox"/> Fitness/Gym Membership	<input type="checkbox"/> 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.

MONTHLY INCOME

Yearly Gross \$ _____

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 <input type="checkbox"/> Rent <input type="checkbox"/>		
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	\$	\$

