



# CARE

**Cancer Aid Resource & Education Inc.**

118 S. Water St.

Las Cruces, NM 88001

575-652-5407 or 575-649-0598

Website: [carelascruces.org](http://carelascruces.org)

Email: [caresupportprogram@carelascruces.org](mailto: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 (APFA Form)

**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 three (3) months of application date for any type of cancer.
- (2) Currently receiving cancer treatment therapies: chemotherapy, radiation or surgery

**Eligible patients receive CARE’s financial assistance up to the cap amount as long as they are in treatment. Eligible patients may submit one application in a lifetime. CARE will review your case for determination. 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)** for submission of your application/documents. After CARE reviews your application, you will be contacted to set up an appointment. We encourage you to bring a family member or caregiver, someone 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 three months) as certified by an oncology physician and provide pathology report.
3. Be in current, **active** treatment: receiving chemotherapy, radiation or surgery.
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. Your income may be up to 400% of the Federal Poverty Limits prior to your cancer diagnosis. You will need to provide proof of income documents and bank statements. This application must be completed and all requested documents submitted prior to approval.
6. Acceptable proof of income:
  - **The most current Federal Income Tax return. If you do not file a Federal Income Tax 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, Housing or public assistance benefit notification, any source of income, or**
  - **If you do not have income: Provide a letter of support from a friend or family member**

## 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 \_\_\_\_\_

Do you live? Las Cruces City Limits \_\_\_ Doña Ana County \_\_\_ Do you? Own \_\_\_ Rent \_\_\_ Payment \$ \_\_\_\_\_

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 ( ) Partner ( ) 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 ( ) None

If employed, What is your occupation? \_\_\_\_\_ Employer/Business \_\_\_\_\_ Per Physician

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 or have a partner, is your spouse or partner employed? ( ) Yes Employer \_\_\_\_\_ ( ) 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 Medicare? ( ) Yes ( ) No Retirement Income? ( ) Yes ( ) No

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

Are you currently receiving income/food/utility/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 aid requires your completion of the Patient Request for Financial Assistance Form.

## 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"/> Transportation – auto payment	<input type="checkbox"/> Utilities	<input type="checkbox"/> Rent – You will need a W-9 from your Landlord & Rental Agreement
<input type="checkbox"/> Mortgage	<input type="checkbox"/> Phone	<input type="checkbox"/> Internet
<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 CURRENT 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-After Diagnosis
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)		
<b>TOTAL HOUSEHOLD GROSS INCOME</b>	<b>\$</b>	<b>\$</b>
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 (SSR/SSI/SSDI) – Provide SS support letter(s)		
Disability – Type: _____		
Unemployment benefits		
AFDC/TANF/SNAP/WIC/LIHEAP – Provide state support letter(s)		
Child Support/Alimony		
Business/Self Employment/Unemployment/Rental income		
Other Income – List type of support		
<b>TOTAL HOUSEHOLD NET INCOME</b>	<b>\$</b>	<b>\$</b>

### MONTHLY EXPENSES

HOUSEHOLD EXPENSES – <u>OUT OF POCKET</u> EXPENSES	Monthly Amount Before Diagnosis	Monthly Amount Current
Home: Mortgage <input type="checkbox"/> Rent <input type="checkbox"/> Housing Assistance <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		
<b>TOTAL HOUSEHOLD EXPENSES</b>	<b>\$</b>	<b>\$</b>

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, How many types?** \_\_\_\_\_ Check below: Case Manager Name \_\_\_\_\_ Phone \_\_\_\_\_

<input type="checkbox"/> Employer Based	<input type="checkbox"/> Medicare A( ) B( ) C( ) D( )	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicare plus Medicaid	<input type="checkbox"/> NM Medical Insurance Pool	<input type="checkbox"/> Affordable Care Act/Marketplace
<input type="checkbox"/> Medicare plus Supplemental Coverage	<input type="checkbox"/> Other:	

**How much do you pay at each doctor/treatment appointment?:**  
 Oncology/Dr. \$ \_\_\_\_\_ Chemotherapy treatment \$ \_\_\_\_\_ Radiologist/Dr. \$ \_\_\_\_\_ Radiation treatment \$ \_\_\_\_\_  
 Yearly deductible \$ \_\_\_\_\_ Maximum yearly out of pocket cost \$ \_\_\_\_\_

**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. Please put a check mark in the parenthesis ( ) that you have included each item. Should you have an item without a check mark, you will have an incomplete application. **Incomplete applications will not be considered.**

**Forms to complete are underlined. Please check mark each item 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 form and sign form)
4. ( ) Pathology Report
5. ( ) Valid ID and Insurance card(s)
6. ( ) Proof of residency in Doña Ana County (copy of mortgage/rental payment receipt, utility bill or voter card)
7. ( ) Water or gas bill
8. ( ) Federal Tax return (State Tax Return if you don't file federal taxes)
9. ( ) One month of employment pay stubs or one month of proof of income or benefits for everyone in your household (employment, unemployment, self employment, pension, retirement, SSI, SSD, AFDC, TANF, SNAP, Housing, etc.). Provide documentation for any source of income or benefit.  
 Or ( ) If no income, please provide letter of support.
10. ( ) 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