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

APPLICATION FOR PATIENT FINANCIAL ASSISTANCE – PHYSICIAN FORM

PHYSICIAN CERTIFICATON OF ACTIVE TREATMENT
(MUST BE COMPLETED BY ONCOLOGIST, RADIOLOGIST or SURGEON)

Your patient applied for financial aid from CARE for non-medical basic living expenses. Your patients' eligibility is based on:
(1) a positive diagnosis of cancer made with a diagnostic biopsy and Pathology Report verifies diagnosis date is within three months of the application date
(2) active therapy is ongoing: chemotherapy, radiation, or surgery

Complete this form for your patient as part of their Application for Patient Financial Assistance. 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 still in active treatment as noted above.

PLEASE NOTE: CARE's aid is for newly diagnosed patients in current ongoing treatment.

Physician Certification of Active Treatment
Complete Below Entirely and 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 If yes, please provide details of treatment plan below. ( ) NO**
- **Please attach copy of pathology report. Date of pathology report's diagnosis**________________

Please Provide Your Patient's Estimated Treatment Plan and Schedule:

Surgery Date: ________________

Chemotherapy: Number of Treatments________ **Frequency**________________________________

Start Date_____________ **End Date**_____________

Radiation: Number of Treatments________ **Start Date**_____________ **End Date**_____________

Level of employment activity suitable for patient ____ None ____Full Time ____Part-Time ___ Hours/Week
Projected date patient can return to work at pre-treatment level:________________________
Patient's diet/food restrictions: __None____ Yes, list____
Exercise program or fitness gym recommended: _____Yes _____No
Name of Oncology/Radiology/Surgeon Treating Physician (please print) ______________________________________

Social Worker Name:________________________Phone ( )_____________ Email:_________________________
MD License #______________________________Hospital/Clinic____
Address____City____
State/Zip________________________Phone ( )________________________Fax ( )_______________________

Signature of Treating Physician ______________________________Date ________________________________