CARE

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

CARE USE ONLY.
Date_____
Patient ID_____
Form# _____
Assistance Today $_____
Balance to Assist $_____

PFD #3

PATIENT REQUEST FOR FINANCIAL ASSISTANCE FORM (PRFA Form)

I, _____(patient printed name), Date of Birth _____, am submitting this request to CARE for financial assistance. I understand the following:

1) My eligibility for financial assistance is valid based on the CARE Support Program Policy.
2) I am eligible to receive assistance since I am in active treatment receiving:
   ( ) chemotherapy ( ) radiation ( ) surgery to treat my cancer.
3) My current active treatment is certified by my oncologist's, radiologist's or surgeon's signature below.
4) My bills that I am submitting are **NOT** in "shut off" status. **If my bill is, I will alert CARE immediately.**
5) My bill's due date is in the current month or within 30 days.
6) I must submit **ORIGINAL** and **CURRENT** bills/invoices/coupons in my name or my spouse's name at my current home address (application address), one invoice per vendor/creditor and up to five bills per month.
7) CARE will **NOT** pay late fees or additional charges due to late or nonpayment of any bills.
8) CARE will pay my bills only by check and mail directly to my vendor/creditor.
9) I must provide an original **PRFA Form** for **each** of my financial assistance requests to CARE.

I. Requests for Bill Payments

( ) I request assistance with my non-medical, basic living expenses bills. I have listed below the detail of my bills to be paid in due date order with earliest due listed first.

VENDOR/CREDITOR (PAYEE)	ACCOUNT HOLDER NAME	DUE DATE OF BILL	ACCOUNT or INVOICE #	AMOUNT	CARE VOUCHER #

II. Request for Food/Nutritional Supplement and Gas Cards

I request assistance for food and nutritional supplement and/or gas cards only. I will NOT purchase non-food items; alcohol, cigarettes/tobacco related products, lottery tickets, electronics or create a process that will allow for cash back.

( ) I am requesting card(s) for the following (check item only). Amount will be based per financial plan.

( ) Food $_____ Card #:_____ **CARE Voucher #**_____

( ) Gas $_____ Card #:_____ **CARE Voucher #**_____

_____ _____ _____
PATIENT SIGNATURE **PHONE NUMBER** **DATE**

CANCER TREATMENT CENTER – PHYSICIAN CERTIFICATION OF ACTIVE TREATMENT

I, Dr._____, with _____ Cancer Treatment Center certify that I am the treating physician for patient _____ and I am currently providing the following active cancer treatment (check): ( ) chemotherapy ( ) radiation ( ) surgery

_____ _____
ONCOLOGIST, RADIOLOGIST or SURGEON SIGNATURE (Original/No Stamps) DATE