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 or record of application requesting assistance maintaining health insurance.

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