CANCER FOUNDATION for NEW MEXICO
Local • Independent • Caring

Patient Assistance Eligibility Application

Eligibility Requirements

You may be eligible for Foundation services such as mileage reimbursement, overnight lodging, or grocery cards if you meet the following criteria:

- You have received a cancer diagnosis, are under the care of a Santa Fe oncologist, are receiving active treatment in Santa Fe such as chemotherapy and/or radiation
- You are a resident of New Mexico and at least 18 years of age
- Your documented income is at or below 300% of the 2023 Federal Poverty Guidelines as described below:

# of Family Members	Gross Monthly Income	Gross Annual Income
1	$3,645	$43,740
2	$4,930	$59,160
3	$6,215	$74,580
4	$7,500	$90,000
5	$8,785	$105,420

Documentation of Income

To qualify for assistance, you must provide proof that you meet the eligibility requirements outlined above. Please submit one of the following with your completed application:

- A copy of your most recent Federal Income Tax Return
- A copy of most recent State Income Tax Return if Federal was not filed
- If you have neither Federal nor State Tax Return documents, please provide an explanation and another form of income verification such as a social security award letter or pay stubs.

Instructions for Completing this Application

- Please fill out the form completely with signature and date at the bottom
- Copies of tax returns or, if applicable, other documents showing income must be attached to this application
- If you qualify for assistance, it will begin on the day the application is completed and accepted. (No mileage assistance will be provided if an applicant is receiving that benefit from another source.)
- Submit your completed application and accompanying documentation via postal mail, email, or fax using the contact information provided below.

Postal Mail	Email	Fax
Cancer Foundation for New Mexico PO Box 5038 Santa Fe, NM 87502	caroline@cffnm.org	(505) 955-7003

Questions?

Please contact Caroline Owen at (505) 955-7931 x. 403 or
Johanna Medina at (505) 955-7931 x. 408.

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Patient Information				
Name:			Date of Birth:	Age:
Mailing Address:	Street	City	State	Zip
Physical Address: (if different from above)	Street	City	State	Zip
County of Residence:			Last 4 digits of SSN:	
Phone Number(s): (H)		(C)	(W)	
Email Address:				
Marital Status:	Single ◯	Married/Partner ◯		
Emergency Contact Name:				
Phone Number:		Relationship to Patient:		
Secondary Contact Name:				
Phone Number:		Relationship to Patient:		

Medical Information			
Diagnosis:		Date of Diagnosis:	
Treating Physician:			
Prescribed Treatment:			
Do you have private health insurance? Yes ◯ No ◯	Name of Company:		
Do you receive Medicaid? Yes ◯ No ◯		Medicare?: Yes ◯ No ◯	

Demographic Information	
The Cancer Foundation for New Mexico collects this information to track distribution of services among diverse populations and to help ensure continued funding for patient programs.	
Hispanic/Latino Origin Yes ◯ No ◯	
◯ Native American	◯ Asian
◯ White	◯ African American or Black
Other (please specify):	

Financial Information				
Employment Status:	Full Time ◯	Part Time ◯	Unemployed ◯	
Job Title:		Employer:		
Are you receiving housing or mileage assistance from any other agencies? Yes ◯ No ◯				
Name of Agency:			Amount of Assistance:	

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Financial Information Continued	
Do you own your home? Yes ◯ No ◯	If yes, list home value:
What is the amount of your monthly rent or mortgage payment?	
Do you have other assets such as savings, stocks, or other property? Yes ◯ No ◯	
If yes, please describe and list values:	

Household Information: Please list everyone who lives with you and their relationship to you.			
Name	Relationship	Age	Employment Status

***Monthly Income:** Please list sources of income for you and your entire household.			
Income Source	You	Spouse/Partner	Others in Household
Wages			
Pension			
Social Security			
Unemployment Benefits			
AFDC / TANF			
Child Support / Alimony			
Food Stamps			
Other			
Total Monthly Income	$	$	$

***Enter your gross monthly wages – these are your earnings before taxes and other withholdings (such as insurance payments) are deducted.

I declare that to the best of my knowledge and belief this information is true, correct, and complete. I understand that if the information which I submit is determined to be untrue, such a determination will result in a denial of services from the Cancer Foundation for New Mexico. I also agree to promptly notify the Cancer Foundation of any changes in my financial situation. I understand that I may need to provide documentation of cancer-related medical appointments.

Signature: _____ Date: _____
(Patient or Legal Guardian)

Revised 2/16/23