CANCER FOUNDATION for NEW MEXICO

Local • Independent • Caring

# Patient Assistance Application

Eligibility requirements. You may be eligible for Foundation services such as Travel to Treatment mileage reimbursement, overnight lodging, grocery or emergency assistance if you meet the following criteria:

**Received a Cancer Diagnosis**
Under the care of a Santa Fe oncologist, receiving treatment in Santa Fe such as chemotherapy and/or radiation

**Residency Requirement**
You are a resident of New Mexico and at least 18 years of age

**Documented Income**
At or below 300% of the 2024 Federal Poverty Guidelines as described below:

| Family Members | Gross Monthly Income | Gross Annual Income |
|---|---|---|
| 1 | $3,765 | $45,180 |
| 2 | $5,110 | $61,320 |
| 3 | $6,455 | $77,460 |
| 4 | $7,800 | $93,600 |
| 5 | $9,145 | $109,740 |

## 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 secure online form below 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.

| Mailing Address | Email | Fax |
|---|---|---|
| Cancer Foundation for New Mexico<br>PO Box 5038, Santa Fe, NM 87505 | assist@cffnm.org | 505-955-7003 |

**Questions?** Please contact Patient Service at (505) 955-7931 x. 403

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## Patient Information - STEP 1

**Full Name**

**Date of Birth** **Age** **Pronouns**

**Email Address**

**Mailing Address**

**City** **State** **Zip Code**

**Physical Address** ☐ Yes, same as mailing address

**City** **State** **Zip Code**

**County of Residence** **Last 4 digits of Social Security Number**

**Phone Number** **Marital Status** Single

**Primary Emergency Contact Name**

**Emergency Contact Phone** **Relationship to Patient**

**Secondary Emergency Contact Name**

**Emergency Contact Phone** **Relationship to Patient**

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## Medical Information - STEP 2

**Cancer Diagnosis** *(Required)*

**Treating Physician**

**Date of Diagnosis** *(month and year)*

**Do you recieve Medicare?**
☐ Yes ☐ No

**Do you recieve Medicaid?**
☐ Yes ☐ No

**Do you have private health insurance?**
☐ Yes ☐ No

## Demographic Information - STEP 3

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

**Ethnicity**
☐ Native American
☐ White
☐ Asian
☐ African American or Black

**Other** *(please specify)*

## Financial Information - STEP 4

**Employment Status** *(Required)*
☐ Full Time
☐ Part Time
☐ Unemployed
☐ Retired
☐ Disability

**Job Title**

**Employer**

**Are you recieving housing or mileage assistance from any other agencies?**
☐ Yes ☐ No

**Name of Agency**

**Amount of Assistance**

**Do you own your home?**
☐ Yes ☐ No

**If yes, list home value**

**Monthly rent or martgage payment**

**Do you have other assest such as savings, stocks, or other property?**
☐ Yes ☐ No

**If yes, please describe and list values:**

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## Household Information - STEP 5

Please list everyone who lives with you and their relationship to you.

| Full Name | Relationship | Age | Employment Status |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

**Monthly Income:** Please list sources of income for you and your entire household.

| Source | You | Spouse/Partner | Others in Household |
|---|---|---|---|
| Income Source | | | |
| 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.

**YES, 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)