CANCER FOUNDATION for NEW MEXICO

Hope for every journey

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 2025 Federal Poverty Guidelines as described below:

Family Members	Gross Annual Income
1	$47,880
2	$64,920
3	$81,960
4	$99,000
5	$116,040

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 PO Box 5038, Santa Fe, NM 87505	assist@cffnm.org	505-955-7003

Questions? Please contact Patient Services. If you are being treated at:

CHRISTUS St. Vincent Regional Cancer Center

Caroline Owen, *Patient Services Coordinator*
caroline@cffnm.org (505) 955-7931 x. 403

Nexus Health

Stacey McMullen, *Patient Services Coordinator*
stacey@cffnm.org (505) 955-7931 x. 408

Patient Information - STEP 1

Full Name

Date of Birth

Age

Email Address

Phone Number

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

Marital Staus

Gender

Primary Emergency Contact Name

Relationship to Patient

Emergency Contact Phone

Secondary Emergency Contact Name

Relationship to Patient

Emergency Contact Phone

Medical Information - STEP 2

Cancer Diagnosis

Prescribed Treatment

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

- ☐ Full Time
- ☐ Part Time
- ☐ Unemployed
- ☐ Retired
- ☐ Disability

Job Title

Employer

Are you recieving housing or mileage assistance from any other source?

☐ 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, IRS, stocks, or other property?

☐ Yes ☐ No

If yes, please list values:

Household Information - STEP 5

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

Full Name	Relationship	Age	Employment Status

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

Income	You	Spouse/Partner	Others in Household
Wages			
Pension			
Social Security			
Disability			
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)