CANCER FOUNDATION for NEW MEXICO

Patient Assistance Eligibility

You may be eligible for Foundation services if you meet the following criteria:

- You have a cancer diagnosis and are receiving treatment in Santa Fe;
- You are a resident of New Mexico;
- You are 18 years old or older;
- Your income is at or below 300% of the 2015 Federal Poverty Guidelines as described below:

Number of Family Members	Gross Monthly Income	Gross Annual Income
1	$ 2943	$ 35,310
2	$ 3983	$ 47,790
3	$ 5023	$ 60,270
4	$ 6063	$ 72,750
5	$ 7103	$ 85,230

If you have questions, about possible eligibility please contact the Cancer Foundation for New Mexico office at [505] 955-7931 ext 3.

If you meet the criteria listed above you must provide a copy of your ***most recent US Income Tax Return***.

If you did not file US tax, please provide a copy of your **New Mexico Income Tax Return.**

If neither were filed, please explain and provide documents showing your income.

CANCER FOUNDATION for NEW MEXICO
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PATIENT ASSISTANCE APPLICATION

Instructions

- This application must be completed, signed and dated prior to approval.
- Tax return copies should be submitted along with this application.
- If you qualify for assistance, it will begin the day the application is completed and accepted.

You may send the completed application and attachments to:
Cancer Foundation for New Mexico
PO Box 5038
Santa Fe, NM 87502

You may fax the application and attachments to:
[505] 955-7003

Patient Name _____

Hispanic ____ Native American ____ County of Residence _____

Mailing Address _____
Street City Zip

Physical Address _____
Street City Zip

Phone (H)_____ Email _____

Phone (cell)) _____ Phone (work) _____

Date of Birth _____ Social Security # _____

Marital Status: _____ Married _____Single (divorced, widowed)

Name of Spouse/partner _____ Phone _____

Other contact person (if needed) _____

Relationship to patient_____ Phone_____

Patient employment status _____

Job Title _____ Employer _____

Diagnosis _____ Date of diagnosis_____

Treating Physician _____

Treatment _____

Do you receive Medicaid? _____ Medicare? _____

Do you have private health insurance? _____ Name of Insurance Co. _____

Are you currently receiving housing or mileage assistance from any other agencies? _____ Yes _____ No

If yes, list agency name and amount of assistance _____

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

Name	Relationship	Age	Employment Status

FINANCIAL INFORMATION

Do you own your home? _____ yes _____no If yes, mortgage payment _____ Home Value _____

If no, what is your rent? _____

Do you have any savings, stocks or other property? _____ yes _____ no

If yes, Savings Amount _____ Stocks _____Property _____

Current month's income _____ Total income for past 3 months _____

Please list **monthly income** for your entire household:

Monthly Income*

Income Source	You	Spouse/Partner	Other Household Members
Wages			
Pension			
Social Security			
Unemployment Benefits			
AFDC/TANF			
Child Support/Alimony			
Food Stamps			
Other			
Total Monthly Income			

* Enter **gross** monthly wages - do not deduct withholding tax or allotments taken out of pay, such as insurance payments, etc.

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.

Signature_____ Date _____

If you have questions, please contact the Cancer Foundation for New Mexico office at [505] 955-7931.