

NEW MEXICO CANCER CENTER FOUNDATION
At the New Mexico Cancer Center
4901 Lang Ave NE, Albuquerque, NM 87109
Phone: 505.828.3789 Fax: 505.857.8480
ADULT PATIENT GRANT APPLICATION



Date of application: _____
NMOHC Physician _____ MR # _____
Are you receiving assistance with chemotherapy drugs? ()Yes ()No
Is this your first application for patient grant? ()Yes ()No

I understand that completion of this application does not guarantee assistance from the Foundation. In order to be considered, all supporting documents showing income and bills outstanding must -accompany this application.
_____ (initials)

Name: _____ Sex: M F Marital status: ___ Age ___ Date of Birth: _____

Address: _____ Apt#: _____

City: _____ Zip: _____

Telephone: _____ Diagnosis: _____

Financial Information

Number of Persons in Household: _____ Ages of dependent children _____

Please list all sources of income per month in your household:

Salary: _____ Work: PT/ FT On disability from work _____

Pension or retirement: _____

Social Security Retirement or disability : _____ Notes:

Unemployment or general assistance : _____

Child support or alimony: _____

Other: _____

TOTAL MONTHLY INCOME: \$ _____

Savings and Other Financial Resources:

Checking account: _____

Savings account: _____

Stocks or bonds: _____

Other Assets: _____

401 K or IRA accounts: _____

Property other than home: _____

TOTAL RESOURCES: \$ _____

Primary Insurance: _____ Secondary Insurance: _____

DESCRIPTION OF FINANCIAL NEED

Why are you requesting a grant from the NM Cancer Center Foundation?

Please list your three most urgent **non-medical** financial needs (for example: PNM bill - \$203.00) and attach the corresponding bills to this application.

----- \$ -----

----- \$ -----

----- \$ -----

TOTAL AMOUNT OF REQUEST: \$ _____

I attest that the above financial information is correct and complete to the best of my knowledge. I further understand that if there are any significant changes to the information provided on this application form I have a responsibility to notify New Mexico Cancer Center Foundation Patient Grant Program.

Release of information: I authorize NMCCF to use and disclose my confidential medical records and financial information to the NM Cancer Center Foundation grant review committee for the sole purpose of reviewing, finalizing, and carrying out the disbursement of patient grants. This confidential information will not be released to any other parties.

Patient or Guardian Signature: _____ Date: _____

PLEASE NOTE: Please remit to the NMCCF in person, by mail or fax. For assistance in completing the application, call or visit the NMCCF social worker. (505) 796-3061. Please include all pertinent non-medical bills and income verification. Grant requests are routinely reviewed each month. The NMCCF grant committee has the discretion to prioritize and award grants based on patient need and available funding. ***Patients are limited to one grant per year. We fund essential needs for applicants who are adult cancer/and or serious hematologic disorder patients.***