Cancer Support Services Application

Date: _____

Name _____Date of Birth _____

Mailing Address _____

Physical Address _____

Phone (home) _____ Email _____

Phone (cell) _____ Marital Status: ☐ Married/Partnered ☐ Single

Name of Spouse/Partner, other support person(s) _____Phone _____

Do you have insurance? ☐Yes ☐No Type of insurance _____

Are you currently receiving assistance from other agencies? ☐Yes ☐No Specify_____

Do you have a good support system? ☐Yes ☐No Do you have others depending on you? ☐Yes ☐No

What types of services are you most interested in? ☐ Lodging ☐ Food ☐ Transportation/gas

☐ yoga ☐ telephone support ☐ massage/acupuncture/fitness coaching ☐ grief and loss counseling

☐ personal care ☐ support group

Cancer Support Services are available to all community members regardless of income.

Signature:_____**Date:**_____

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Cancer Support Services Client –

Please complete top section and sign, then submit to the doctor to complete the Medical information section. Completed form needs to be returned to Cancer Support Services office.

Patient name _____ **DOB:** _____

Patient Signature _____ **Date:** _____

Medical Information for Cancer Support Services Qualification

To be completed by Primary Care or Oncologist's office

Date of Diagnosis: _____ Primary Cancer/Diagnosis_____

Is the patient on active treatment? ☐Yes ☐No Treatment start date _____

If No, Date of last treatment_____(qualifies for assistance up to 1 year post treatment)

Primary Care Physician in Taos ☐Yes ☐No Name, if Yes _____

Oncologist's Name: _____ Hospital/Clinic/Practice: _____

Address: _____ City, State, Zip: _____

Phone: ( ) _____ FAX: ( ) _____

Signature of Medical Professional: _____DATE:_____

Please return this portion of the application to Cancer Support Services

SCAN and EMAIL to CancerSupportServices@taoshospital.org

(Or) FAX: (575) 751-7052

Cancer Support Services, 413 Sipapu Street, Taos, NM 87571—PH: (575)-751-8927

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