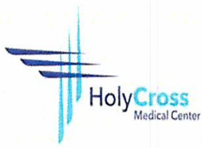


# Cancer Support Services Application

Date: ____________________

*We provide non-medical services to help people experiencing cancer and their family members to meet basic needs, ease stress, and promote quality of life. Services include: help with transportation and food costs, housecleaning, meal preparation, errands, massage, yoga, cancer and fitness coaching, and more.*

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?** ☐ housecleaning ☐ help with errands and/or meal preparation ☐ lodging help ☐ help with food ☐ help with transportation/gas ☐yoga ☐ massage/acupuncture ☐ health coaching or fitness coaching ☐ personal care ☐support group ☐ grief and loss support ☐other____________________________________________________________

**If you fall under the following income guidelines please sign & date below for funding purposes:**

*(Income must be under the amount specified for the number in your household.)*

| Annual Income Guidelines - Department of Human Services<br>April 01, 2018 - March 31, 2019 | | |
|---|---|---|
| **HOUSEHOLD Size** | **Monthly Income** | **Annual Income** |
| **1 person** | $3,035.00 | $36,420.00 |
| **2 persons** | $4,115.00 | $49,380.00 |
| **3 persons** | $5,195.00 | $62,340.00 |
| **4 people** | $6,275.00 | $75,300.00 |
| **5 persons** | $7,355.00 | $88,260.00 |
| **6 persons** | $8,435.00 | $101,220.00 |
| **7 persons** | $9,515.00 | $114,180.00 |
| **8 persons** | $10,595.00 | $127,140.00 |

**Signature:** ________________________________________ **Date:** ___________________________

# Medical Information

**Please have your primary care physician's office or oncologist's office complete this section**

Date of Diagnosis: ________________________ Primary Cancer/Diagnosis________________________________

Treatment _______________________________ Treatment start date ___________________________

Is the patient in active treatment? ☐Yes ☐No If No, Date of last treatment:_____________

Primary Care Physician in Taos ☐Yes ☐No Name if Yes ___________________________________

MD name: _______________________________ Hospital/Clinic/Practice: ________________________

Address: _________________________________ City, State, And Zip: ________________________________

Phone ( ) ______________________________ FAX: ( ) ___________________________________

Signature of Medical Professional: __________________________________________________________

**Please return this portion of the application by FAX to: Cancer Support Services**
**Phone:** (575) 751-8927 **FAX:** (575) 751-7052

***(Cancer Support Services Client - Please fill in information below before submitting to doctor for return to us.)***

**Patient name** ____________________________________________________ **DOB:** _________________

**Signature** _______________________________________________________ **Date:** _________________

Cancer Support Services, 413 Sipapu Street, Taos, NM 87571