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

Have you been a resident of Taos County for at least 90 days? ☐Yes ☐No Total number of household members:_____

If living in a single-person home:

Does your annual gross income fall below $32,091? ☐ Yes ☐ No

Do you have liquid assets greater than $10,000 in checking/savings? ☐ Yes ☐ No

If living with 2 or more household members:

Does your gross annual income fall below $48,136? ☐ Yes ☐ No

Do you have liquid assets greater than $20,000 in checking/savings? ☐ Yes ☐ No

Proof of income and residency will be required for funding purposes if qualified for Taos County grant award.

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

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