



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: _____

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 print and complete this application, then call us for more information: (575) 751-8927

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