CANCER ASSOCIATION OF LOUISIANA
GENERAL CANCER PROGRAM ELIGIBILITY CRITERIA:

Patient must be able to check each box to be eligible

To qualify for a program, patients must meet certain eligibility criteria.
□ US Citizen or permanent resident
□ Currently in treatment for a Diagnosis of cancer
Are you in active treatment?

Active treatment is defined as the period after a positive diagnosis of cancer has been made, and during which therapies are being administered, including surgical procedures (e.g. tumor removal, single or bi-lateral mastectomy, lumpectomy, axillary dissection, or sentinel node biopsy), chemotherapy or radiation. Active treatment does not include reconstruction surgeries or long-term hormonal therapies.

□ Has or is in the process of securing private, independent, Cobra or government health insurance. (If you do not have insurance you must provide documentation explaining why and if you are currently seeking insurance coverage)

THESE DOCUMENTS ARE REQURED

Please fax, email or mail to CAGNO with your application.

Please provide the following documents from each applicable section listed below:

□□Proof of Identity required:
Copy of government issued ID

□□Proof of income: examples
Income tax – 1040ez page 1; 1040 pages 1-2;
Spouses' income – W2 or W9
Social Security determination letter
Bank statements indicating a social security deposit
Food stamp budget slip or Louisiana Purchase card
Medicaid card or proof of free care
No income verification sheet - only if you have no income

□□Proof of insurance – if no insurance, please explain the reason. Example: Medicaid coverage pending…

□□If patient's household income has recently changed because they are no longer working or are unpaid leave, the same documentation (tax return, etc.) is required. In addition the following documentation is required:
□A statement of change indicating how the household income has changed
□Documentation of the stated change – examples include:
□Employee termination letter
□Final check stub indicating termination date

824 Elmwood Park Boulevard; Suite 154, New Orleans, LA 70123-3347
Within Metro New Orleans (504) 733-5539 Outside Metro New Orleans 1-800-624-2039 Fax (504) 733-0252
www.calacares.org

PATIENT SERVICES ELIGIBILITY FORM

UPON COMPLETION, YOU CAN MAIL THE APPLICATION TO THE ADDRESS ABOVE OR SEND VIA FAX

Patient Information

Today's Date_____

Name_____ Date of Birth _____

Street Address (No PO Box) _____Apartment_____

City _____ Zip _____ Parish_____

Mailing Address (if Different)_____

Telephone Number _____SSN#_____

RACE _____ SEX _____ Email address, if applicable _____

Financial Information

TOTAL HOUSEHOLD INCOME per Month (please include patient, spouse and minor child)

$_____ Household Income

Salary: $_____ Social Security $_____ Disability $_____ Other$_____

Employment Status: Employed_____ Unemployed_____ Retired_____ Disabled_____

Marital Status: Single_____ Children _____ if so, # of children under the age of 26yrs. still living in household _____

Couple____ Children _____ if so, # of children under the age of 26yrs. still living in household _____

Do you currently use tobacco in any form? ___ YES ___ EX-TOBACCO USER ___ NEVER USED TOBACCO

Would you like information on quitting tobacco use? _____Yes _____No

Would you like to receive an uplifting note card every now and again? _____Yes _____No

**Healthcare Insurance Information *(select all that apply)*

_____ *I do not have healthcare insurance. If you do not have insurance,
_____**I have applied to Medicaid/Medicare and it is pending,*
_____**I have been denied coverage through Medicaid, Medicare or the affordable healthcare Please submit a copy of the denial*
_____**I have had significant changes in my financial status throughout the year.*

**If you are asking for prescription assistance and are currently uninsured but obtain insurance at a later date, you are <u>required</u> to notify CALA and your assigned pharmacy immediately. This will not disqualify you from services provided by CALA but will allow CALA to help others in need.*

PLEASE NOTE:

Failure to comply with any of the above will result in you being disqualified from the patient services program. IF YOU HAVE INSURANCE AND YOU DO NOT PROVIDE INSURANCE INFORMATION TO CALA AND THE PHARMACY ASSIGNED TO YOU BY CALA, YOU WILL BE DISQUALIFIED FROM THE PROGRAM.

Insurance Co_____ Policy ID #: _____

Are you enrolled in a Medicare Plan? Yes or no Medicare Policy #: _____

Does the policy cover prescription drugs? ___Yes ___No ___Unsure

Do you have Medicaid? ___Yes ___No

My Medicaid application is pending ___Yes ___No

PATIENT REQUEST ASSISTANCE WITH THE FOLLOWING: Submit documentation such as # of appointments and miles traveled for transportation, Prescriptions or co-pays please include costs if known. If funding permits for Medical co-pays or Utilities and if you are requesting this assistance please included a copy of the bill.

Requested need	what to include	item
Prescriptions – those only related to Cancer Treatment Medical Co-pays	Include cost and pharmacy if known Include copy of the Bill	
DME supplies	Such as Bed pads, diapers, equipment	
Gas/food cards	# trips and Est mileage Include treatment schedule	
Nutrition	Boost Farmers Market where available Walmart cards for food purchase	

By signing this you are confirming the patient is in active treatment, hospice or palliative care because of their cancer. Exceptions can be made for those whose last treatment has within 12months*

1. **Treating Oncologist - _____SIGNATURE _____**

CURRENT TREATMENT FACILITY: _____

ADDRESS_____ _____

DEPARTMENT'S TELEPHONE NUMBER(S) _____DEPARTMENT'S FAX _____

Diagnosis – Patient WAS DIAGNOSED WITH Stage 0 1 2 3 4 CANCER type _____

ON _____ WITH Mets to _____

**All information in this section is required and must signed by treating Oncologist.*
**Active treatment (chemotherapy, radiation, surgery).*

****By signing this form, I understand that the Cancer Association can provide only the generic equivalents (unless no generic equivalent is available from any of the pharmaceutical companies) and I hereby authorize the use of generic equivalents to be substituted for medications that are prescribed for the above-named patient and paid for by the Cancer Association. I also authorize the Cancer Association to obtain needed information to determine my eligibility for requested assistance.**

_____ _____

SIGNATURE of Referring Professional & Title **(PRINTED NAME** of Referring Professional

_____

Referring Telephone Fax number Referring Email Address

_____

SIGNATURE of Patient **(required)** If not the patient, name and relationship to patient of person supplying the information