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.
 Louisiana 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). Insurance status will not disqualify you from services provided by CALA

THESE DOCUMENTS ARE REQURED

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

Proof of Identity required:
Copy of government issued ID

Proof of income: Any one of the following are accepted

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

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

PATIENT SERVICES ELIGIBILITY FORM

201 Evans Rd, Suite 319
New Orleans, LA 70123
(504) 733-5539 Fax (504) 733-0252 www.calacares.org

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

Today's Date_____

Patient Information

Name_____ Date of Birth _____

Street Address (No PO Box) _____Apartment_____

City _____ Zip _____ Parish_____

Mailing Address (if Different)_____

Telephone Number _____ Email address, if applicable _____

Demographics – collected for grant purposes

RACE _____ **GENDER** - □Female □ Male □ Transgender

Total Household Income per month (please include patient, spouse and minor child) $_____

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)*

Type of Insurance
□ Medicaid
□ Medicare Plan
□ Commercial
□ 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
_____*I have had significant changes in my financial status throughout the year.

REQUESTED ASSISTANCE: Submit documentation such as # of appointments and miles traveled for transportation, please include costs if known.

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

All information in this section is required and must signed by treating Oncologist.

Patient was diagnosed with CANCER type _____ Stage 0 1 2 3 4

Diagnosis date if known_____ if the cancer has metastasized Mets to _____

By signing this form, I authorize the Cancer Association to obtain needed information from my treatment team for requested assistance.

_____

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

Current Treatment Facility: _____

Treating Oncologist - _____ SIGNATURE _____

_____ _____

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

_____ _____

Referring Telephone & Fax number Referring Email Address

*By signing, 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 been within the last 12months*

**Active treatment (chemotherapy, radiation, surgery).*