

**San Juan Medical Foundation**  
**Riley Men's Health Fund**

**Application for Financial Assistance – CONFIDENTIAL**

**Application must be complete to process**

Date: \_\_\_\_\_ Date of Birth : \_\_\_\_\_ San Juan County, NM Resident: Yes \_\_\_ or No \_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Race/Ethnicity (Required for grant reporting) Asian \_\_\_\_\_ Hispanic \_\_\_\_\_ Caucasian \_\_\_\_\_  
African American \_\_\_\_\_ Native American \_\_\_\_\_ Other \_\_\_\_\_

Employer: \_\_\_\_\_ # of Dependents in household: \_\_\_\_\_

Primary Medical Insurance Company: \_\_\_\_\_

Do you have medical coverage under any of the following?

Medicare: \_\_\_\_\_ Medicaid: \_\_\_\_\_ Supplemental Insurance: \_\_\_\_\_ IHS: \_\_\_\_\_ Other: \_\_\_\_\_

What is your diagnosis? \_\_\_\_\_

Treating Physician's Name: \_\_\_\_\_ Clinic/Office: \_\_\_\_\_

Amount of funding requested: \$ \_\_\_\_\_ Payable to: \_\_\_\_\_

Other Resources Applied for: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Office Use Only**

Date Received: \_\_\_\_\_ Amount Approved: \_\_\_\_\_

Declined (Y/N): \_\_\_\_\_ Reason for decline: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date Approved: \_\_\_\_\_

**Guidelines**

1. This fund is designed to provide financial assistance to underinsured or low income men, 18 years or older in need of medical services.
2. Must reside in San Juan County, NM, or be receiving treatment in San Juan County.
3. Funding to be utilized only for current diagnosis or treatment of no more than 6 month retro. Medical bills that are 6 months or older will not be covered, including those at a collection agency.
4. Any remaining balance is the responsibility of the client. San Juan Medical Foundation will not be considered a secondary insurance.
5. Applicants are encouraged to seek other sources of Funding such as County Indigent Fund 505-334-4288 and/or San Juan United Way 505-326-1195.
6. Covered services may include medical exams, procedures, medication and other health related services.
7. Questions or concerns, contact the SJR Cancer Center Nurse Navigator at 505-609-6089.
8. Completed applications should be turned in to 730 S. Lake Street, faxed to 505-609-2272, emailed to [mwarren@sjrmc.net](mailto:mwarren@sjrmc.net) or mailed to San Juan Medical Foundation, PO Box 110, Farmington, NM 87499-0110.