CPS Staff Use Only
Charity Tracker Case #: _____

Cancer Patient SERVICES

PLEASE PRINT CLEARLY

Date: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ Zip: _____ County: _____

E-mail: _____ Home Phone: _____ Cell: _____

Can messages be left at the above phone numbers? ☐ Yes ☐ No

What is the best time to contact you? ☐ Anytime ☐ Morning ☐ Afternoon ☐ Evening

Race/Ethnicity:

☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander
☐ Other ☐ Prefer not to disclose

Date of Birth: ____/_____/_____ **Gender** ☐ M ☐ F

Are you? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you a Veteran? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No ☐ **Disabled** ☐ **Laid off** ☐ **Unemployed** ☐ **Student**

If yes, where are you employed? _____ ☐ Full-time ☐ Part-time

☐ **RETIRED - FROM?** _____ **YEAR RETIRED** _____

Individual Annual Income: $_____ **Household Annual Income** $_____

Source of Income: _____

(Information has no affect on eligibility for CPS services, but is needed for grant reporting purposes)

Other Household Members:

Name	**Relationship to Client**	**Date of Birth --/--/----**

Housing Status:

☐Home- Own ☐Home-Rent ☐Apartment ☐Shelter ☐Live with Relatives

☐ Live with Others ☐Other: _____

Name of Primary Caregiver OR **Emergency Contact**: _____ Relationship:_____

Phone: _____Cell: _____ Work No:_____

Address: _____City: _____Zip: _____ County:_____

Who is your Oncologist/Radiologist? □Dr. Cole/Haq □ Dr. Ashraf □Dr. Thomas □Dr. Lutz

□Other:_____ Phone No._____

Who is your Primary Care Physician? _____ Phone No. _____

How were you referred to Cancer Patient Services?

□ Physician(s) Office/Name: _____ □ Hospital/Name_____

□ Nurse Name/Office: _____ □ Social Worker, Name/Office: _____

□ Friend: _____ □ Other/Name: _____ □ Word of Mouth

What has your doctor told you so far?

Diagnosis: _____ Stage: _____Onset_____

Treatment Plan:

Do you have health insurance? □ Yes □ No Annual Deductible $_____

If yes, is it? □ Private/Employer □ Medicare □ Medicaid
□ Other: _____

If no, are you in the process of getting health insurance coverage? □ Yes □ No

Please explain where you are in the process: _____

_____

Check all benefits that you are currently receiving:

□Social Security □Social Security Supplemental Income (SSI)

□Social Security Disability Income (SSDI) □Veteran's Administration (VA)

□Food Assistance (JFS) □Cash Assistance (JFS) □Medical Assistance (Medicaid) □WIC

□Other: _____

Will you be transporting yourself to treatment? ■Yes □No

If no, who will be transporting you? _____

How do you feel Cancer Patient Services can help you best?

What is your native language? □ English □ Other _____

What other languages do you speak? _____ What other languages do you write? _____

What other languages do you read? _____

In what language(s) do you feel the most comfortable when you are hearing new information?

□English □Other:_____

Which of the following methods is most helpful when learning about your health? (Check all that apply)

□ Reading □ Watching a Video □ Listening (Person to Person) □Personal demonstration

Who do you have available to help you at this time with issues such as cooking, cleaning, transportation, child care, other support needs, etc.?

Name: _____ Relationship: _____ Contact number: _____

Assistance available for: _____

Name: _____ Relationship: _____ Contact number: _____

Assistance available for: _____

Name: _____ Relationship: _____ Contact number: _____

Assistance available for: _____

What other *agencies* are you currently working with?

1. Name: _____ Contact Person: _____

What services are they providing you with? _____

Are those services meeting your needs? _____

2. Name: _____ Contact Person: _____

What services are they providing you with? _____

Are those services meeting your needs? _____

CONTINUED ON NEXT PAGE

3. Name: _____ **Contact Person:** _____

What services are they providing you with? _____

Are those services meeting your needs? _____

I am interested in receiving supportive services from the Cancer Patient Guide.

Client Signature: _____ **Date:** _____

If Client is unavailable to sign:
Caregiver Signature: _____ **Date:** _____

□Decline Cancer Patient Guide Services

I have received the Notice of Privacy Practices at Cancer Patient Services.

Client Signature: _____**Date:**_____

If Client is unavailable to sign:
Caregiver Signature: _____ **Date:** _____

Equipment Loan Agreement.

I agree to return the equipment/materials that I have borrowed from CPS in good condition and agree to pay for any damages to the equipment while in my possession. I will not hold CPS liable for any injury that I may sustain while using the equipment that they provided to me.

Client Signature: _____**Date:**_____

If Client is unavailable to sign:
Caregiver Signature: _____ **Date:** _____