Cancer Services Client Intake Form

505 E. Perkins Ave. Sandusky, OH 44870
Phone: 419-626-4548 Fax: 419-502-0222

Please **print clearly** and complete both sides of this form. Your personal and household information is kept confidential. *Services are provided free of charge for qualifying cancer patients and are made possible by the generosity of local donors and foundation grant funding. For a full list of foundations that help support Cancer Services please visit our*

Website: www.cancerresources.org

PROFILE: **DATE:**__________________

Name: ______________________________________ Male ___ Female___ Birth Date : ____/______/____ Age: ____

Address: ______________________________________ City: _____________________ State: ______Zip: _______

County: ________ Phone: (______)_____________________Email:______________________________________

Marital Status: Married ______ Single ______Divorced _______Widowed_______

Race: Caucasian _______ African American ________ Hispanic ________ Other: ______________________

Emergency Contact: ____ Phone ________________________________

Relationship to Client _______________________________________

PHYSICIAN AND DIAGNOSIS: **I understand Cancer Services may need to speak with my medical provider, social worker or other support staff and grant permission for this contact: _____________________Signature Required

1. Physician/Oncologist ____
name/s address phone

2. Diagnosis/Type of Cancer _________________________Stage_________ Date of Diagnosis ___________________

3. Are you receiving: Chemo _____Radiation _____Date therapy began or will begin ____________________________

ASSISTANCE OR PROGRAMS REQUESTED: *please check all that apply*

___ ***Prescription Assistance**
___ **Nutritional Supplements** (Boost, Ensure, Carnation, Instant Breakfast, etc.)
___ ***Transportation or Mileage Reimbursement**
___ **Medical Equipment** (Wheelchairs, walkers, bedside commodes, shower chairs, etc.)
___ **Medical Supplies** (dressings, tapes, incontinent supplies, etc.)
___ **Wigs and/our Mastectomy Items** (wigs, hats, turbans, breast prosthesis, bras)
___ **Support Services**: Journals, support groups, community resources
___ **Other**:____

HEALTH INSURANCE

1. Medicare: Part A___ Part B___ Part D___ No ___ Medicaid: Yes____ No____ Provider: ____________

2. Have you applied for assistance at Job & Family Services? Yes______ No_______

3. Other insurance __________________________________ Are you a Veteran? Yes _____ No ______

4. Do you have any Rx drug plan? Yes ___ No___ Name of drug plan __________________________

*** EMPLOYMENT AND FINANCIAL INFORMATION:** **Some services are available based on income including mileage reimbursement and prescription assistance.*

Are you currently employed? ____Yes ____No

If No, were you employed before diagnosis? ____Yes _____No   Are you on medical leave? _____Yes _____No

Number of people in household: ________ *Please list others besides yourself living in the home.*

Name: ____________________________ Age: ______ Relationship to you: *(spouse, child, etc)*_________________

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Name: ____________________________ Age: ______ Relationship to you: *(spouse, child, etc)*_________________

TOTAL MONTHLY FAMILY (HOUSEHOLD) INCOME : $_______________ (Including Spouse)

Proof of income is required for **Mileage Reimbursement** and **Prescription Assistance** programs.

Wages/Employment	$ ________	Social Security	$_________	Pension	$ ________
Public Assistance	$_________	Short-term Disability	$ ________	SSD or SSI	$ ________
Unemployment	$_________	Family/friends	$_________	Other	$ ________

How did you hear about Cancer Services: *Please circle those that apply*

Cleveland Clinic   Fisher-Titus Medical Center   Seidman Cancer Center   Facebook

Website   Family   Friend   Doctor   Nurse   Other___________________

I ATTEST THAT THE INFORMATION PROVIDED IS TRUTHFUL TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT GIVING FLASE INFORMATION WILL RESULT IN THE LOSS OF ELIGIBILTY OF SERVICES:

Patient's Signature____Date________________

or Authorized representative____ Date________________

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FOR OFFICE USE ONLY:

Date form received: _______________

Services Approved: ____

Approved by: __________________________________