505 E. Perkins Avenue
Sandusky, OH 44870
www.CancerResources.org

Phone: (419) 626-4548
Fax: (419) 502-0222
CancerServicesPatients@gmail.com

Cancer Services Client Intake Form

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 more information, please visit our website or Facebook page.

PROFILE:

Name: | ☐Male ☐Female | **Date of Birth:**

Address:

City: | **Zip Code:** | **County:**

Phone: ( ) **Email:**

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

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

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Race: ☐White ☐Black or African American ☐Hispanic ☐Asian
☐American Indian or Alaska Native ☐Prefer not to disclose ☐Other

Emergency Contact: **Phone:** ( )

Relationship:

PHYSICIAN AND DIAGNOSIS:

Physician Name:

Location: | **Phone:** ( )

Type of Cancer: | **Stage:** | **Date of Diagnosis:**

Are You receiving? ☐Chemo ☐Radiation ☐Immunotherapy | **Therapy start date:**

Will you be transporting yourself to treatment? ☐Yes ☐No

If no, who will be transporting you?

How were you referred to or heard about Cancer Services?

☐Physician Office/Name:			
☐Hospital/Name:			
☐Nurse Name/ Office:			
☐Social Worker Name/Office:			
☐Friend/Family	☐Facebook	☐STS Bus/Billboard	☐Online
☐Other:			

EMPLOYMENT AND FINANCIAL INFORMATION

Are you currently working? ☐Yes ☐No ☐Disabled ☐Laid Off ☐Unemployed ☐Retired ☐Student

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

Yearly Income: *(Information has no effect on eligibility for CS Services, but is needed for grant reporting purposes)*

☐$0 -$20,000	☐$20,000 - $25,000	☐$25,000-$29,000
☐$29,000-$32,000	☐$32,000-$60,000	☐$60,000-$100,000
☐Other:		

Do you have health insurance? ☐Yes ☐No | Annual Deductible: $

If yes, is it? ☐Private/Employer ☐Medicare ☐Medicaid ☐Other

Are you a Veteran? ☐Yes ☐No

Check all benefits that you are currently receiving:
☐Social Security ☐Social Security Supplemental Income (SSI) ☐WIC
☐Veteran's Administration (VA) ☐Social Security Disability Income (SSDI)
☐Job and Family Services ☐Other

What other agencies are you currently working with? (*EX: Serving Our Seniors, Hospice, Community Action Commission)*

Agency Name:
What services are they providing you with?
Agency Name:
What Services are they providing you with?

ASSISSTANCE OR PROGRAMS REQUESTED *(Check all that apply)*

☐Prescription Assistance	☐Medical Supplies
☐Transportation or Mileage Reimbursement	☐Medical Equipment
☐Nutritional Supplements	☐Support Services
☐Wigs and Mastectomy Items	

I am interested in receiving supportive services from Cancer Services.

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

I give Cancer Services permission to speak to my medical provider, social worker, or other support staff.

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 Cancer Services in good condition. I will not hold Cancer Services liable for any injury that I may sustain while using the equipment that they have provided to me.

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