CANCER SERVICES
Resources. Support. Education.

505 E. Perkins Avenue
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www.CancerResources.org

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Cancer Services Client Intake Form

Please print clearly or type 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: ○ Erie ○ Huron ○ Ottawa

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 ○ Asian ○ Other
○ Hispanic ○ American Indian or Alaska Native ○ Prefer Not to Disclose

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 NameOffice:_____
- Social Worker Name/Office: _____
- Friend/Family Facebook STS Bus/Billboard Online
- Other: _____

Employment And Financial Information

Are you currently working? Yes - If yes, where are you employed? _____

Full Time Part Time

No Disabled Retired Laid Off Unemployed Student

Yearly Income (Information has no effect on eligibility for Cancer Services services, but it 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)
- Veterans' Administration (VA)
- Social Security Disability Income (SSDI)
- Job & Family Services
- WIC
- 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? _____

Assistance 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 workers, 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: _____