JAY COUNTY CANCER SOCIETY

Cancer Service Client Intake Form

MAILING ADDRESS: PO Box 614 Portland, IN 47371

OFFICE ADDRESS: 227 N. Meridian St. Portland, In 47371

MESSAGE LINE:
(260)726-8110

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 Jay County Residents and are made possible by the generosity of local donors and foundation grant funding. For more information, please visit our website or Facebook page.

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

Address: _____

City: _____ **Zip Code:** _____ **County:**_____

Phone: _____ **Can messages be left at this phone number?** ☐ Yes ☐ No

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

Email:

_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White or Caucasian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Asian ☐ Middle Eastern or North African ☐ Prefer Not to Disclose

Caregiver/Emergency Contact

Name: _____ **Phone:** _____ **Relationship:** _____

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Name of Oncologist: _____

Treatment Hospital: _____ **City:** _____

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

Are you receiving? ☐ Chemotherapy ☐ Radiation☐ Immunotherapy ☐ Other _____

Therapy Start Date: _____ **Will you be transporting yourself to treatment?** ☐ Yes ☐ No

If no, who will be transporting you? _____

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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 _____

Are you currently working? ☐ Yes - Where are you currently employed? _____

☐ Full Time ☐ Part Time

☐ No ☐ Disabled ☐ Laid Off ☐ Unemployed ☐ Retired ☐ Student ☐ Other

Current Total of Annual Household Income (Information has no effect on eligibility for Cancer Services, but it is needed for grant reporting purposes.)

☐ $0-$20,000 ☐ $20,000-$25,000 ☐ $25,000-$30,000 ☐ $30,000-$35,000 ☐ $35,000-$40,000 ☐ $40,000-$50,000 ☐ $50,000-$60,000 ☐ $60,000-$70,000 ☐ $70,000-$80,000 ☐ Over $80,000

Family Income Sources: (Please check all that apply)

☐ Salary ☐ Social Security ☐ Pension ☐ Retirement Savings ☐ SSD (Disability) ☐ Short or Long-Term Disability ☐ Unemployment ☐ Family or Friend Support ☐ Other:

_____

Number of people in the household: _____ Do you have health insurance? ☐ Yes ☐ No

If you have health insurance, is it? ☐ Medicare ☐ Medicaid ☐ Private Insurance _____

☐ Other _____ **Annual Deductible:** $_____

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Are you a veteran? ☐ Yes ☐ No

Please check all benefits that you are currently receiving:

☐ WIC ☐ Veterans' Administration (VA) ☐ Job & Family Services ☐ Other _____

What other agencies are you currently working with? (For example, Serving Our Seniors, Hospice, Community Action Commission, Care & Share, Cancer Tees Me Off, When Pigs Fly)

Agency Name: _____

What services are they providing you with? _____

Programs Requested (Please check all that apply)

☐ Nutritional Supplements ☐ Transportation ☐ Mileage Reimbursement ☐ Prescription Assistance ☐ Medical Supplies ☐ Medical Equipment ☐ Wigs & Mastectomy Items ☐ Educational Resources

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

_____

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

Client/caregiver Signature: _____ Date: _____