CPS Staff Use Only
Charity Tracker Case #: ___________________

CLIENT REGISTRATION FORM

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:_____________________________________

CLIENT REGISTRATION FORM

Name of Primary Caregiver OR **Emergency Contact**: ___________________________ Relationship: _______________

Phone: ___________________________Cell: ____________________________ Work No:__________________________

Address: ___________________________City: ____________________Zip: ___________ County:__________________

Who is your Oncologist/Radiologist? Dr. Cole ◻ 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, write, or 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? *(Ex: Christian Clearing House, PAN, Hospice)*

1. Agency Name: ______________________________**Contact Person:** ____________________________

What services are they providing you with? ____

Are those services meeting your needs? ____

2. Agency Name: ______________________________**Contact Person:** __________________________

What services are they providing you with? ____

Are those services meeting your needs? ____

CLIENT REGISTRATION FORM

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: ______________________