Cancer Support Community Arizona (CSCAZ)
ADULT ANNUAL INFORMATION FORM 2017

CSCAZ gathers information about every member to help us better understand who comes to our programs. All personal information will be kept confidential. CSCAZ is a non-profit organization that offers our program at no cost to our participants. We rely solely on donations to underwrite our programs, and we use the following information to help us secure funding. The information provided to funders will be only in terms of combined demographic data of all participant with no identifying information. Your answers to these questions will, in no way, affect your ability to access all services at CSCAZ at no charge. PLEASE PRINT CLEARLY. *THANK YOU!*

Date:_____ **Location:** ❑ **Main Campus at Palm Lane** ❑ **Other** _____

❑ Ms. ❑ Mrs. ❑ Miss ❑ Mr. ❑ Other _____

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone: (Hm)_____ **(Cell)**_____

Email:_____

Many of our members enjoy reminders and updates about our programs. You will be automatically added to these lists. If you would prefer not to be added, please check the box: Email Weekly Program Reminder ❑ Email Monthly Community News ❑

Emergency Contact:_____**Relationship:**_____

Phone: (Hm)_____**(Wk)**_____**(Cell)**_____

PLEASE COMPLETE THE FOLLOWING ABOUT YOURSELF:

Is this the first time that you have attended one of our programs? Yes ☐ No ☐

If no, what year did you first attend a program?_____

I came here because ❑ I am a Person with Cancer / Survivor ❑ I am a Support Person / Caregiver (Family, Friend)

❑ Other_____

Cancer Diagnosis(es) impacting myself/loved one:_____

Where do/did you or your loved one receive the majority of treatment?_____

Gender: ❑ M ❑ F **Date of Birth:**_____ **Age:** ❑ 18-24 ❑ 25-39 ❑ 40-55 ❑ 56-69 ❑ 70+

Ethnicity: ❑ White (not Hispanic) ❑ Black/African American (not Hispanic) ❑ White - Hispanic ❑ Black – Hispanic ❑ Asian/Pacific Islander

❑ American Indian/Alaska Native/First Nations ❑ Other_____

Educational Level: ❑ High School ❑ GED ❑ Undergraduate degree ❑ Graduate degree ❑ Other_____

Employment Status: ❑ Employed full or part-time ❑ On medical leave ❑ Disabled ❑ Not employed ❑ Retired

Type of Insurance: ❑ Uninsured ❑ Medicare only ❑ Medicare + Private ❑ Medicaid/AHCCCS ❑ Private Insurance (list):_____

Annual Family Income (optional): ❑ under $25,000 ❑ $25,000-49,999 ❑ $50,000-74,999❑ $75,000-99,999 ❑ $100,000+

Number in household:_____ **Are you a Veteran? Yes ☐ No ☐**

Do you have child(ren) in your life under the age of 18? Yes ☐ No ☐

How did you hear about CSCAZ? ❑ Friend/Family ❑ Internet / Website ❑Community Organization ❑ Healthcare Professional

❑ Health Fair/Expo **Name of person/place that referred you, please be specific:**_____

Title:_____ **Hospital/Office:**_____ **City/State:**_____

I understand that my photo may be taken at certain events and allow CSCAZ to use this photo. Initial:_____

I understand that I am voluntarily participating in the program services offered by Cancer Support Community Arizona. I hereby assume all related risks and release any liability of CSCAZ and its representatives for any injury or property damage that may occur. Signature:_____ **Date:**_____