

# 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: \_\_\_\_\_