CANCER SUPPORT COMMUNITY

TUBA CITY REGIONAL HEALTH CARE CORPORATION

The Cancer Support Community

ANNUAL VISITOR INFORMATION FORM

The Cancer Support Community gathers information to help us better understand who comes to our programs. All personal information will be kept confidential. Since we are a non-profit organization that does not charge for our services, we rely solely on donations to underwrite our programs, and we need the following information to help us secure funding. The information provided to funders will be only in terms of combined demographic data of all Members with no identifying information. Your answers to these questions will, in no way, affect your ability to access all programs at the Cancer Support Community at no charge. PLEASE PRINT CLEARLY. *THANK YOU!*

Date:_____**Location: (add list of locations/off-site/satellite) ❑ Other** _____

Today I am attending: _____

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

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

Phone: (Home) ( )_____(Cell) ( )_____ (E-Mail) _____

Date of Birth: _____ **Gender:** □ Male □ Female □ Other □ Rather Not Say

May we use your mail or email address for correspondence about other upcoming programs and special events?

Mail: ❑ Yes ❑ No Email: ❑ Yes ❑ No

Do you have children between the ages of 5 and 18? ❑ Yes ❑ No If yes, what age(s):_____

How did you hear about CSC? ❑ Doctor ❑ Nurse ❑ Social Worker ❑ Friend/Family ❑ Printed/Newspaper

❑ TV/Radio ❑ Website ❑ Social-Media ❑ CSC Staff/Volunteer ❑Other_____

If you were referred by a health care professional, please complete the following:

Name of person who referred you: _____**Hospital/Office:** _____

City: _____ **State:** _____

PLEASE COMPLETE THE FOLLOWING ABOUT YOURSELF:

I am registering as a: (check one) ❑ Person with Cancer ❑ Support Person ❑Healthcare professional ❑ Volunteer ❑ Other _____

If you are a support person, what is the name of the person with cancer that you support?_____

PLEASE COMPLETE THE FOLLOWING FOR YOURSELF OR FOR THE PERSON YOU ARE HERE TO SUPPORT:

Cancer Diagnosis: _____**Date Diagnosed:**_____

Oncologist's Name: _____**Hospital:**_____**City/ST:** _____

I give you my permission to let my oncologist know I am attending the Cancer Support Community. ❑ Yes ❑ No

The following questions are optional and are used to help us better understand whom we are serving, and any groups that may be underserved.

Marital status: □ Single □ Coupled □ Domestic partnership □ Married □ Divorced □ Widowed

Race/Ethnicity: ❑ American Indian/Alaska Native/ First Nations ❑ Asian/Pacific Islander ❑ Other _____

. ❑ Black/African American (Not Hispanic) ❑ Black – Hispanic ❑ White (non-Hispanic) ❑ ❑ White- Hispanic

Insurance: ❑ Medicare only ❑ Medicare ❑ Medicaid/MediCal ❑ Private Insurance ❑ VA Health Care ❑ Uninsured ❑ Other:_____

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

Annual Household Income: ❑ under $25,000 ❑ $25,000-49,999 ❑ $50,000-74,999 ❑ $75,000-99,999 ❑ over $100,000

Do you have electricity? ❑Yes ❑No **Do you have running water?** ❑Yes ❑No **Do you have livestock?** ❑Yes ❑No

How do you heat your home? _____

Thank You!

For Office/Data Input Only: Interview Date: _____Group #: _____Facilitator: _____
Data Input Date:_____ (1/1/2007; 6/2010; 12/2011; 7/2018; 11/2021; 10/2023)