H.O.P.E.
Helping Others *through* Peer Experiences

The James
THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

H.O.P.E. at The James
Partner Application

Thank you for your interest in H.O.P.E. (Helping Others *through* Peer Experiences). The H.O.P.E. Program connects cancer patients or caregivers to someone who has had a similar experience with cancer.

A **Partner** is a patient at The James, or their caregiver, who is looking for information and support from someone who has had a cancer experience.

Individuals who are interested in becoming Partners must fulfill the following criteria to be considered for the program:

- Be eighteen (18) years of age or older
- Be a patient or a caregiver of a patient receiving treatment at The James

Note: Patients can be newly diagnosed with cancer, currently undergoing treatment or have completed treatment.

A **Guide** is someone who has had a cancer experience and is trained to offer appropriate peer support.

If you have questions, please call **614-293-8771**.

Applications can be faxed to 614-293-9622, Attn: H.O.P.E. Program, or mailed to:
James*Care* for *Life*/H.O.P.E.
660 Ackerman Road – 5th floor
P.O. Box 183109
Columbus, OH 43218

*** Have you or someone you cared for received medical services at The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OSUCCC — James)?** ☐ Yes ☐ No

CONTACT INFORMATION

*** I am applying as a:** ☐ Patient ☐ Caregiver

*** First name:** _____ *** Last name:** _____

Preferred name (if different than listed): _____

*** Street address:** _____

*** City:** _____ *** State:** _____ *** ZIP/Postal:** _____

*** Country:** _____ **Province:** _____

Time Zone: (select one) ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific ☐ Alaska ☐ Hawaii

*** Primary phone number:** _____ ☐ Home ☐ Cell ☐ Work

Secondary phone number: _____ ☐ Home ☐ Cell ☐ Work

*** Best time to call: (select all that apply)**

Weekday: ☐ Morning ☐ Afternoon ☐ Evening

Weekend: ☐ Morning ☐ Afternoon ☐ Evening

*** Email:** _____

* Response required

***How did you hear about H.O.P.E.? (select all that apply)**

- ☐ Another patient at The James
- ☐ Caregiver/family member/friend
- ☐ H.O.P.E. staff
- ☐ Member of The James Care Team – oncologist/nurse/social worker

  Staff name: _____
- ☐ James volunteer
- ☐ James*Care* for *Life*/H.O.P.E. brochure
- ☐ Patient and Family Resource Center
- ☐ H.O.P.E. website
- ☐ H.O.P.E. materials displayed at a James facility (inpatient or outpatient)
- ☐ Received information in the mail about H.O.P.E.
- ☐ New patient packet at The James
- ☐ Social media
- ☐ Other _____

DEMOGRAPHIC INFORMATION

*** Date of birth (mm/dd/yyyy):** _____ / _____ / _____

*** Gender:** ☐ Male ☐ Female ☐ Queer/Nonbinary ☐ Transgender female (male-to-female)
☐ Transgender male (female-to-male) ☐ Self-Identify: _____ ☐ Prefer not to disclose

*** Sexual Orientation:** ☐ Straight or Heterosexual ☐ Gay, Lesbian or Homosexual ☐ Bisexual ☐ Other: _____
☐ Don't Know ☐ Prefer not to disclose

*** Primary language:** ☐ English ☐ Spanish ☐ Other: _____

*** Race: (select all that apply)**

- ☐ African American / Black
- ☐ Asian / Pacific Islander
- ☐ Hispanic / Latino
- ☐ American Indian
- ☐ Caucasian / White
- ☐ Other _____

Marital status:

- ☐ Single
- ☐ Significant other
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Widowed

Employment status:

- ☐ Full time
- ☐ Disabled
- ☐ Retired
- ☐ Student
- ☐ Part time
- ☐ Unemployed
- ☐ Homemaker

CANCER-RELATED QUESTIONS: The following questions are related to the person diagnosed with cancer.

*** Patient age at diagnosis:** _____

*** Type of cancer:**

- ☐ Acute lymphoblastic leukemia
- ☐ Acute myeloid leukemia
- ☐ Anal cancer
- ☐ Basal cell carcinoma
- ☐ Benign hematology
- ☐ Bladder cancer
- ☐ Bone & spine sarcoma
- ☐ Bone cancer
- ☐ Brain cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Chronic lymphocytic leukemia
- ☐ Chronic myeloid leukemia
- ☐ Colon cancer
- ☐ Cutaneous lymphoma
- ☐ Endocrine cancer
- ☐ Endometrial cancer
- ☐ Esophageal cancer
- ☐ Gallbladder cancer
- ☐ Gastrointestinal cancers
- ☐ Gastrointestinal carcinoid tumors
- ☐ Genitourinary cancers
- ☐ Gliomas
- ☐ Gynecologic cancers
- ☐ Hairy cell leukemia
- ☐ Head & neck cancers
- ☐ Hemophilia
- ☐ Hodgkin's lymphoma
- ☐ Kaposi sarcoma
- ☐ Kidney cancer
- ☐ Laryngeal cancer
- ☐ Leukemia
- ☐ Lip & oral cavity cancer
- ☐ Liver cancer
- ☐ Lung cancers
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Merkel cell carcinoma
- ☐ Multiple myeloma
- ☐ Myelodysplastic syndrome
- ☐ Neuroendocrine cancer
- ☐ Non-Hodgkin's lymphoma (B- & T-cell)
- ☐ Ocular melanoma
- ☐ Oropharyngeal cancer
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Parathyroid cancer
- ☐ Pituitary tumor
- ☐ Prostate cancer
- ☐ Rectal cancer
- ☐ Sarcoma
- ☐ Sickle cell anemia
- ☐ Skin cancers
- ☐ Skull base tumors
- ☐ Small intestine cancer
- ☐ Soft tissue sarcoma
- ☐ Spine tumors
- ☐ Squamous cell carcinoma
- ☐ Stomach (gastric) cancer
- ☐ Testicular cancer
- ☐ Thrombotic thrombocytopenic purpura
- ☐ Thyroid cancer
- ☐ Vaginal cancer
- ☐ Von Willebrand disease
- ☐ Vulvar cancer
- ☐ Other _____

Subtype of cancer: _____

Stage of cancer: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Unknown

*** Cancer treatment status:**

- ☐ Newly diagnosed
- ☐ Currently in treatment
- ☐ Finished treatment less than 1 year ago
- ☐ Finished treatment between 1 and 5 years ago
- ☐ Finished treatment more than 5 years ago
- ☐ Living with cancer as a chronic illness
- ☐ Receiving hospice or palliative care
- ☐ Other _____

Did this cancer recur? (Did this cancer come back?) ☐ Yes ☐ No ☐ I'm not sure

Did this cancer metastasize? (Did this cancer spread?) ☐ Yes ☐ No ☐ I'm not sure

*** Has there been a diagnosis of any other type of cancer?** ☐ Yes ☐ No

If yes, what type of cancer? _____

TREATMENT INFORMATION: The following questions are related to the person diagnosed with cancer.

*** Name of treating physician or practitioner at The James:** _____

*** Please indicate which treatments have been received: (select all that apply)**

- ☐ Bone marrow transplant
- ☐ Chemotherapy
- ☐ Clinical trial
- ☐ Complementary/alternative treatment
- ☐ Hormonal therapy
- ☐ Immunotherapy
- ☐ Radiation
- ☐ Stem cell transplant
- ☐ Surgery: _____
- ☐ Wait and watch
- ☐ Other: _____

*** Please indicate which side effects have been experienced: (select all that apply)**

- ☐ Allergic reactions
- ☐ Anxiety
- ☐ Appetite changes
- ☐ Balance issues
- ☐ Bone pain
- ☐ Bowel management
- ☐ Burns
- ☐ Chemo brain
- ☐ Fatigue
- ☐ Fertility changes
- ☐ Flexibility issues
- ☐ Graft vs. host disease
- ☐ Hair loss
- ☐ Infection
- ☐ Lymphedema
- ☐ Mobility issues
- ☐ Mouth sores
- ☐ Nausea
- ☐ Neuropathy
- ☐ Phantom pain
- ☐ Sexual dysfunction
- ☐ Sleep disturbance
- ☐ Urinary issues
- ☐ Other:_____

SUPPORT QUESTIONS

Which of the following topics are you interested in discussing with your Guide? (select all that apply)

☐ Patients: (select all that apply)

- ☐ Communicating with healthcare team
- ☐ Communicating with family and friends
- ☐ Coping
- ☐ Day-to-day life
- ☐ Diagnosis
- ☐ Fear of recurrence
- ☐ Information/resources
- ☐ Parenting
- ☐ Self-image
- ☐ Side effects
- ☐ Test results/prognosis
- ☐ Other:_____

☐ Caregivers: (select all that apply)

- ☐ Communicating with healthcare team
- ☐ Communicating with family and friends
- ☐ Coping
- ☐ Managing finances
- ☐ Providing physical care for the patient
- ☐ Providing emotional support to the patient
- ☐ Taking care of myself
- ☐ Time management
- ☐ Understanding caregiving options
- ☐ Understanding the patient's medical condition, treatment and prognosis
- ☐ Other:_____

We will make every effort to match you with a Guide who has had a similar cancer experience. Matching criteria may include diagnosis, age and gender. Other criteria may be included as appropriate. Please list any other match criteria that are important to you:

_____

_____

_____

FOR CAREGIVERS ONLY: (IF APPLYING AS A PATIENT – PLEASE GO TO PAGE 6)

*** Are you the patient's primary caregiver? (Primary caregiver is defined as the person mainly responsible for a patient's care.)** ☐ Yes ☐ No

What is your relationship to the cancer patient for whom you provide care?

☐ Spouse/significant other ☐ Sibling ☐ Friend
☐ Parent ☐ Family member (not listed above) ☐ Other:_____
☐ Child

Patient's gender: ☐ Male ☐ Female ☐ Please self-identify:_____

How long have you been providing care for the patient?

☐ Less than 1 month ☐ 6 months to 1 year ☐ 1 to 6 months
☐ 1 to 2 years ☐ 2 to 5 years ☐ More than 5 years

As a caregiver, I am responsible for: (select all that apply)

☐ Emotional support
☐ Personal care (i.e., assisting with bathing, dressing, grooming, eating, toileting, exercises, etc.)
☐ Medical care (i.e., managing medications, administering medications, dressing change, etc.)
☐ Household management (i.e., meal preparation, housekeeping, laundry, shopping, pet care, errands, etc.)
☐ Respite (i.e., fill in for a primary caregiver when they are unable to provide care due to illness, vacation or simply need to take a break)
☐ Taking the patient to appointments
☐ Speaking with physicians on behalf of the patient
☐ Helping the patient to make medical decisions
☐ Providing monetary support to the patient
☐ Other_____

As a result of caregiving, please indicate which areas below have affected you: (select all that apply)

☐ Career/job
☐ Relationships
☐ Emotional health
☐ Physical health
☐ Finances
☐ Leisure activities
☐ Other_____

GUIDELINES FOR PARTICIPATION

These guidelines are intended to create positive cancer journey experiences through compassionate peer connections. I understand that the following are expected behaviors of the Guide.

Guides will:

- Use the skills learned in training to listen carefully to Partners' concerns and fears, guide them to identify priorities and resources, and help them recognize their own strengths and resources to cope.
- Share information about resources available at The James as indicated by Partners' needs.
- Respect the values and decisions of Partners.
- Hold Partners' information in confidence by not releasing confidential information to any unauthorized person or discussing confidential information in a manner that will lead to unauthorized persons obtaining this information.
- Share Partners' confidential information with the program manager at any time, including when a Partner's feelings and needs are beyond the scope of the program and professional help may be required.
- Immediately contact the program manager if a Partner poses a threat to their safety or to the safety of others.

Guides will NOT:

- Recommend or give opinions about specific treatments, medical protocol or medical professionals.
- Provide medical advice or make decisions for others.
- Impose personal values, religious beliefs, dietary practices, etc., on Partners.
- Discriminate against Partners based on race, gender, religion, national origin, sexual orientation or disability.
- Provide transportation, food, money or care to Partners.
- Engage in a romantic, physical or sexual relationship with Partners.
- Promote personal business or distribute its promotional materials to Partners.
- Neglect or abandon Partners without making reasonable arrangements with the program manager for his or her continued support.

CONSENT FOR PARTICIPATION

I hereby confirm that the information provided in the above application form is true and complete to the best of my knowledge. I understand that providing false information may disqualify me from consideration as a participant in the H.O.P.E. Program.

- I understand my participation in the H.O.P.E. Program is completely voluntary.
- I understand that my personal and medical information will be entered into a secure database for purposes of matching me with another participant of the H.O.P.E. Program.
- I understand that my personal and medical information provided in the above web application form will be released to any person with whom I will be matched in the program.
- If I choose to no longer participate in the H.O.P.E. Program, I will notify the program manager, and my personal and medical information will not be released after that date of notification.

CONFIDENTIALITY AGREEMENT

Except as otherwise stated in this document, any information you submit to the H.O.P.E. Program will remain confidential. The information may be used by the H.O.P.E. Program staff for the purpose of establishing connections between you and other participants of the H.O.P.E. Program, and to help assess the performance of the program in achieving its goals.

- Any private information you obtain about other participants of the H.O.P.E. Program is to remain personal and confidential at all times.
- Notwithstanding the foregoing, Guides may discuss with the program manager confidential information about their Partners at any time. Guides will immediately contact the program manager if he or she believes that his or her Partner poses a threat to their safety or to the safety of others.
- Breach of this agreement, intentional or unintentional, may result in termination of your participation in the H.O.P.E. Program.

RELEASE OF INFORMATION

I authorize the H.O.P.E. Program to release my contact information, matching criteria (such as cancer type, treatment, unique matching characteristics and match status) from the H.O.P.E. Program to the person with whom I am matched for the purpose of making a proper match between a Guide and a Partner.

- I expressly consent to the release of information designated above.
- This authorization is valid for 365 days, unless revoked by my written notice, provided the written notice is received prior to release of any of the designated information.
- Information released by this authorization may no longer be protected by federal privacy rules such as HIPAA.
- The revocation of this authorization is effective except as indicated in our Notice of Privacy Practices.
- I understand that The Ohio State University Wexner Medical Center cannot condition my treatment or payment for health care on this authorization unless treatment is research-related or the care was provided solely to provide information to a third party.

In the event it is needed, please list the name and number of an emergency contact:

Name/Relationship: _____ Phone Number: _____

In the event we need to contact your care team, please list the name of your primary oncologist and office information for us to contact:

Primary Oncologist: _____ Phone Number: _____

We will use the email you have provided to send program updates, information and surveys. Please check the box if you do not wish to receive emails: ☐ I do not want to receive emails from the H.O.P.E. Program.

I have read and agree to the Guidelines for Participation, Consent for Participation and Confidentiality Agreement.

_____

First Name Last Name Phone Number Email Address

_____

Signature Date