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

Thank you for your interest in H.O.P.E. (Helping Others through Peer Experiences). Our H.O.P.E. program provides limited-term one-to-one peer support that assist patients and caregivers (survivors) in adjusting to living with, through and beyond a diagnosis of cancer. We provide this support by facilitating confidential connections between trained volunteers whose experiences with cancer are similar to those currently needing support through their cancer journey. Eligibility for this program is determined by receiving treatment at The James, but not being employed there.

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

*** Are you currently employed by the Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Solove Research Institute (The James)?** ☐ Yes ☐ No

In this program there are two distinct roles for which cancer survivors can become involved. Guides are those individuals who have gone through a cancer diagnosis as a patient or caregiver and who are emotionally ready to support others in their journey. Guides use their experiences to help make an enormous difference in the lives of those who need to be heard, supported, and encouraged. Partners are patients and caregivers who are seeking support from someone who may understand what they are going through.

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

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 Rd – 5th Floor
P.O. Box 183109
Columbus, Ohio 43218

CONTACT INFORMATION

*** First Name:** ______________________________ **MI:** ______

*** Last Name:** ______________________________ **Preferred Name:** ______________________

*** 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:** ____

*** 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
- ☐ James Volunteer
- ☐ James*Care* for *Life* Brochure
- ☐ Patient and Family Resource Center
- ☐ H.O.P.E. Web Page
- ☐ H.O.P.E. Materials Displayed at a James Facility (Inpatient or Outpatient)
- ☐ Other ________________________________

Please check the box next to each type of email communication you consent to receive from H.O.P.E. If you leave any boxes unchecked, you will not receive those types of emails from our program. (Select all that apply)

- ☐ H.O.P.E. Newsletter
- ☐ James*Care* for *Life* Brochure
- ☐ Survivorship Resources
- ☐ Patient Education Resources
- ☐ Upcoming Events

DEMOGRAPHIC INFORMATION

*** Date of Birth (mm/dd/yyyy):** ____ / ____ / __________ *** Gender:** ☐ Male ☐ Female

* **Primary Language:** ☐ English ☐ Spanish **Secondary Language:** ☐ English ☐ Spanish

Other Language: ____________________________

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

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

Marital Status:

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

Employment Status:

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

CANCER QUESTIONS

The following questions are related to the person diagnosed with cancer for whom you provide caregiving.

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

- ☐ Spouse / Significant Other
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Family Member (not listed above)
- ☐ Friend
- ☐ Other_________________

Patient's Gender: ☐ Male ☐ Female

*** Patient's Age at Diagnosis:** __________

*** Patient's Type of Cancer: (select all that apply)**

- ☐ 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: ____

Patient's Stage of Cancer: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Unknown

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

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

*** Has this patient been diagnosed with any other type of cancer?** ☐ Yes ☐ No

TREATMENT INFORMATION

The following questions are related to the person diagnosed with cancer for whom you provide caregiving.

*** Name of patient's treating physician or practitioner at The James:** ____

*** Please indicate which treatment(s) the patient has 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 the patient has 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______________________ ________________________

CAREGIVER QUESTIONS

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

How long have you been providing care for the patient?

- ☐ I'm just starting out (less than 1 month)
- ☐ 1 to 6 months
- ☐ 6 months to 1 year
- ☐ 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__________________ ______________________

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

- ☐ Communicating with healthcare team
- ☐ Coping
- ☐ Communicating with family and friends
- ☐ Paying bills and managing finances
- ☐ Providing emotional support to the patient
- ☐ Providing physical care to the patient
- ☐ Taking care of myself
- ☐ Time management and prioritizing
- ☐ 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:

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GUIDELINES FOR CONSENT

As part of the application process, we require you to read and sign the H.O.P.E. program's guidelines for participation, consent for participation, and confidentiality agreement.

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 his or her 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 her/his continued support.

Consent for Participation

I hereby confirm that the information provided in the above web 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 H.O.P.E. program staff for the purpose of establishing connections between you and other participants of 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/she believes that his/her Partner poses a threat to his or her 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.

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

Signature____Date____________________________