



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). The H.O.P.E. Program matches cancer patients or caregivers looking for peer support 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.

A **Guide** is someone who has had a cancer experience and is trained to offer appropriate peer support. A Guide is at least one year past active cancer treatment or caregiving of a patient at The James.

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:
JamesCare for Life/H.O.P.E.
660 Ackerman Rd – 5th Floor
P.O. Box 183109
Columbus, Ohio 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 Solove Research Institute (The James)?** Yes No

CONTACT INFORMATION

* 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: _____

*** 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
- JamesCare 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)
- Received information in the mail about H.O.P.E.
- New patient packet at The James
- The James' social media account
- Other _____

DEMOGRAPHIC INFORMATION

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

* **Primary 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

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

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 _____

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 _____

CANCER-RELATED QUESTIONS

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

Patient's Gender: Male Female

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

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Acute Lymphoblastic Leukemia | <input type="checkbox"/> Genitourinary Cancers | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Acute Myeloid Leukemia | <input type="checkbox"/> Gliomas | <input type="checkbox"/> Pancreatic Cancer |
| <input type="checkbox"/> Anal Cancer | <input type="checkbox"/> Gynecologic Cancers | <input type="checkbox"/> Parathyroid Cancer |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Hairy Cell Leukemia | <input type="checkbox"/> Pituitary Tumor |
| <input type="checkbox"/> Benign Hematology | <input type="checkbox"/> Head & Neck Cancers | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rectal Cancer |
| <input type="checkbox"/> Bone & Spine Sarcoma | <input type="checkbox"/> Hodgkin's Lymphoma | <input type="checkbox"/> Sarcoma |
| <input type="checkbox"/> Bone Cancer | <input type="checkbox"/> Kaposi Sarcoma | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Brain Cancer | <input type="checkbox"/> Kidney Cancer | <input type="checkbox"/> Skin Cancers |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Laryngeal Cancer | <input type="checkbox"/> Skull Base Tumors |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Small Intestine Cancer |
| <input type="checkbox"/> Chronic Lymphocytic Leukemia | <input type="checkbox"/> Lip & Oral Cavity Cancer | <input type="checkbox"/> Soft Tissue Sarcoma |
| <input type="checkbox"/> Chronic Myeloid Leukemia | <input type="checkbox"/> Liver Cancer | <input type="checkbox"/> Spine Tumors |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Lung Cancers | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Cutaneous Lymphoma | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Stomach (Gastric) Cancer |
| <input type="checkbox"/> Endocrine Cancer | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Endometrial Cancer | <input type="checkbox"/> Merkel Cell Carcinoma | <input type="checkbox"/> Thrombotic Thrombocytopenic Purpura |
| <input type="checkbox"/> Esophageal Cancer | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Thyroid Cancer |
| <input type="checkbox"/> Gallbladder Cancer | <input type="checkbox"/> Myelodysplastic Syndrome | <input type="checkbox"/> Vaginal Cancer |
| <input type="checkbox"/> Gastrointestinal Cancers | <input type="checkbox"/> Neuroendocrine Cancer | <input type="checkbox"/> von Willebrand Disease |
| <input type="checkbox"/> Gastrointestinal Carcinoid Tumors | <input type="checkbox"/> Non-Hodgkin's Lymphoma (B- & T-Cell) | <input type="checkbox"/> Vulvar Cancer |
| | <input type="checkbox"/> Ocular Melanoma | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Oropharyngeal Cancer | |

Subtype of Cancer: _____

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

*** Patient's Cancer Treatment Status:**

- | | |
|---|---|
| <input type="checkbox"/> Newly diagnosed | <input type="checkbox"/> Finished treatment more than 5 years ago |
| <input type="checkbox"/> Currently in treatment | <input type="checkbox"/> Living with cancer as a chronic illness |
| <input type="checkbox"/> Finished treatment less than 1 year ago | <input type="checkbox"/> Receiving hospice or palliative care |
| <input type="checkbox"/> Finished treatment between 1 and 5 years ago | <input type="checkbox"/> 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 which 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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hormonal Therapy | <input type="checkbox"/> Wait and Watch |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Immunotherapy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Clinical Trial | <input type="checkbox"/> Radiation | _____ |
| <input type="checkbox"/> Complementary /
Alternative Treatment | <input type="checkbox"/> Stem Cell Transplant | |
| | <input type="checkbox"/> Surgery | |

* Please indicate which side effects the patient has experienced: (select all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergic Reactions | <input type="checkbox"/> Fertility Changes | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Flexibility Issues | <input type="checkbox"/> Phantom Pain |
| <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> Graft vs. Host Disease | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Balance Issues | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Bone Pain | <input type="checkbox"/> Infection | <input type="checkbox"/> Urinary Issues |
| <input type="checkbox"/> Bowel Management | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Mobility Issues | _____ |
| <input type="checkbox"/> Chemo Brain | <input type="checkbox"/> Mouth Sores | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

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:

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 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.

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: _____ Office Information: _____

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
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Signature	Date
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