Creating Access Care Reimbursing Expenses | Lazarex CANCER FOUNDATION www.lazarex.org

P O Box 741 Danville, CA 94526
Phone: 925-820-4517 Fax: 925-552-7305
www.lazarex.org
FORM: CA-PNQ REV: 081921

Dear Applicant,

Thank you for contacting Lazarex Cancer Foundation for help with identifying your clinical trial options. It is our mission to connect cancer patients to clinical trials so you can continue to stay engaged in your fight against cancer.

In order to ensure a timely turnaround for processing your request for clinical trial navigation assistance, please be sure to fill out the application completely. Upon receiving the application, a member of our Patient Services Team will contact you. If you have any questions, please email patientservices@lazarex.org or call 925.820.4517.

Sincerely, The Lazarex Patient Services Team

APPLICATION INFORMATION

Complete applications are reviewed in the order they are received.

In documents you send to us, please cross out any social security number.

A Lazarex Patient Services Coordinator will contact the applicant by telephone to review the information received. Contact is limited to two (2) attempts. The applicant is responsible for all follow up.

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FOR LCF STAFF USE ONLY

Date Received:

PATIENT NAVIGATION QUESTIONNAIRE

☐ New Application ☐ Re-Applying Today's Date: _____

Applicant is:

☐ Patient (proceed to patient information) ☐ Patient representative - Name: _____

Your relationship to patient: ☐ Self ☐ Spouse ☐ Family member ☐ Friend ☐ Health care professional

Phone Number: _____ Email Address: _____

PATIENT INFORMATION (please print clearly)

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ Preferred Phone: _____

City, State, Zip: _____ Alternate Phone: _____

County: _____ Email Address: _____

Sex the patient was assigned at birth on the original birth certificate: ☐ Male ☐ Female

Does the patient speak English? ☐ Yes ☐ No

What is the preferred language for communications with Lazarex? _____

Does the patient have a translator? ☐ Yes ☐ No

Translator Name: _____

Relation: _____

Phone Number: _____

Race / Ethnic Origin: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ Mutli-Ethnic ☐ White ☐ Other (please specify): _____

TOTAL ANNUAL FAMILY INCOME	Number of people in household:

How did the patient hear about us? ☐ Another Patient ☐ Doctor/Nurse/Trial Coordinator ☐ Family/Friends ☐ Medical Facility ☐ News/Media/Internet ☐ Social Worker ☐ Events

☐ Other Organization (please specify): ☐ Other (please specify):

INSURANCE INFORMATION

Does the patient have health insurance? ☐Yes ☐No

Insurance Type: ☐Medicaid-Managed Care ☐Medicaid-State ☐Medi-CAL ☐Private/Commercial ☐Tricare ☐Medicare Standard ☐Medicare-Advantage ☐Other (please specify): _____

HEALTH HISTORY

Primary Cancer: _____ **Current Stage:** _____

Previous Cancer Treatment: (check all that apply)

Chemotherapy:	Yes ☐	No ☐	If yes how many types of chemotherapy: _____		
Radiation:	Yes ☐	No ☐	Surgery:	Yes ☐	No ☐
Immunotherapy:	Yes ☐	No ☐	Targeted Therapy:	Yes ☐	No ☐
Hormone Therapy:	Yes ☐	No ☐	Previous Clinical Trial:	Yes ☐	No ☐

Other Chronic Diseases: (check all that apply)

Heart Disease:	Yes ☐	No ☐	History of Liver Disease (not related to cancer):	Yes ☐	No ☐
Chronic Kidney Disease:	Yes ☐	No ☐	Chronic Lung Disease (Asthma COPD):	Yes ☐	No ☐
Stroke:	Yes ☐	No ☐	Alzheimer's Disease or Dementia:	Yes ☐	No ☐
Hypertension (High Blood Pressure):	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐
High Cholesterol:	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐
Diabetes:	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐
Heart Attack:	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐

Are there any issues that would prevent the patient from traveling? ☐Medical ☐Family ☐Other (please explain) _____

Has the patient had Molecular Testing related to cancer? (see definition below) ☐Yes ☐No

Is the patient interested in undergoing Molecular Testing related to cancer, at possibly no cost to the patient? ☐Yes ☐No

Molecular Testing—or "tumor genomic profiling"—is a form of testing that classifies tumors based on genetic make-up to help diagnose and treat cancer. Using a blood test or biopsy, this testing examines the DNA of cancer cells, looking for genetic mutations that have been acquired by these cells. Every tumor is unique to the patient therefore it is important to understand the unique characteristics of your type of cancer. Molecular testing does this.

ADDITIONAL INFORMATION (optional)

The following set of questions are for statistical purposes to be used only by Lazarex and will not affect whether the patient receives navigation assistance from Lazarex Cancer Foundation.

What is the highest degree or level of school the patient completed?

☐ Less than a high school diploma ☐ High school degree or equivalent ☐ Bachelor's degree (e.g. BA, BS) ☐ Master's degree (e.g. MA, MS, MEd)

☐ Doctorate (e.g. PhD, EdD) ☐ Other: (please specify) _____

☐ Student - if student, what grade? _____

If comfortable sharing, what Faith does the patient follow?

Access to technology: ☐ Computer ☐ Smart phone ☐ Tablet ☐ Printer

Occupation: ☐ Veteran ☐ Active Duty ☐ Reservist

Hobbies or talents?

In the future, would the patient like to share their story, photo and experience with Lazarex Cancer Foundation. ☐ Yes ☐ No

Is the patient a U.S citizen? ☐ Yes ☐ No

Does the patient identify as:

☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Decline to Answer

☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female

☐ Additional gender category/ (or Other), please specify: _____

Lazarex Cancer Foundation is committed to the principles of equitable access to services. Lazarex prohibits discrimination against any person on the basis of race, color, national origin, age, disability, sexual orientation, gender or gender expression, marital, familial, or parental status, religion, genetic information, military status, political beliefs, immigration status, or any other status protected under local, state, or federal law, in connection with its programs and activities. This policy extends to all personnel decisions, terms and conditions of employment, vendor contracts, and the provision of services. We are committed to providing an inclusive and welcoming environment for all members of our staff, volunteers, subcontractors, vendors, and patients. Lazarex Cancer Foundation is a 501 (c)(3) non-profit organization. Our tax identification number is 20-2562494.

Fax this form to 925-552-7305 or email to patientservices@lazarex.org or mail to Lazarex Cancer Foundation, P.O. Box 741, Danville, CA 94526. Lazarex Cancer Foundation will review this information and contact the person requesting reimbursement assistance.