Caregiving Mentor Program

Participant Application Form

☐ Auxiliary Mentoring ☐ Traditional Mentoring

Auxiliary Mentoring: Occasional check-ins and messages of encouragement

Traditional Mentoring: More consistent check-ins and on-going communication

Participant's Name: ____
First Last

Address: ____
Street/Apt.

____
City State Zip

E-Mail Address: ____

Home Phone Number: ____________________ **Cell Phone Number:** ____________________

Preferred Contact: ☐ Email ☐ Home Phone ☐ Cell Phone

Date of Birth: _____/ _____/_____ **Age:** __________ **Sex:** ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children: Girls _____ Age(s) at time of diagnosis ______________________
Boys _____ Age(s) at time of diagnosis ______________________

Ethnic Origin: ☐ African American ☐ Asian American ☐ Caucasian ☐ Hispanic/Latino
☐ Native American ☐ Other ______________________________

Referral Source: ☐ Self-referral ☐ Healthcare Provider ☐ Relative / Friend ☐ Mentor Volunteer
☐ Community Organization or Agency ☐ Other (please specify) ______________________

Relationship to the Patient: ____

Patient's Diagnosis: ____________________________ **Date of Diagnosis:** ____________

Patient's Treatment (if applicable)

____ Chemotherapy Type: ____

____ Radiation Type: ____

____ Surgery Type: ____

Patient's Prognosis: ____

What are the greatest challenges you face as a caregiver? ______________________________
____
____

Please check your top three choice on how you would like to be connected to a mentor:

☐ Patient's Diagnosis ☐ Patient's Stage ☐ Patient's Treatment Plan ☐ Race
☐ Marital Status ☐ Employment ☐ Children ☐ Gender ☐ Age

Additional information to help us best facilitate a mentor: ______________________________
____
____

Participant's Signature: ____ **Date:** ____________

Please return your application to:

CancerConnects, Inc.
Attn: Administrative Specialist
PO Box 2010
East Syracuse, NY 13057

or by email to:
officecancerconnects@gmail.com

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FOR OFFICE USE:

Date Application Received: ____________________ Date Assigned: ____________________

Assigned Volunteer Mentor's Name: ______________________________

Initial Contact Date: ____________________ Type of Contact: ☐ Phone ☐ In Person ☐ Email

Community Referrals (if any): ____
____

Additional Comments: ____
____
____

CancerConnects Caregiving Mentor Program

Participant Consent Form

- I understand as a participant in this program I will be matched with a mentor who was a caregiver and similar to me in terms of life circumstances and the patient's diagnosis and prognosis when possible. My mentor will have participated in an orientation-training program.
- I understand that all CancerConnects Volunteer Mentors will keep in extreme confidence any information provided by myself and/or family members at all times. This statement covers medical status, personal or family life, and opinions expressed by myself and/or family members. Limitations to this policy are the following: suspected child abuse and neglect, dangerousness to self/others, cognitive impairment resulting in an inability to adequately care for myself.
- I understand the mentor is a layperson who is not trained to give medial or psychological advice.
- I understand the contact with my mentor will be either over telephone, e-mail, or face-to-face in a public meeting place.
- I agree to have my name, my caregiver history, telephone number, and e-mail given to the mentor in order for him/her to contact me.
- I understand my participation in this program is completely voluntary.

Name (please print): ____

Address: ____
____

Phone Number: ____

Email: ____

Signature: ___________________________________ Date: _______________________