



Memory Opportunity Referral Package- Part I

Instructions to Referral Agent:

All Memory Opportunity referral candidates must meet all the eligibility requirements listed below prior to making a referral. Please submit the referral form by postal mail or via fax.

Eligibility Requirements:

All referral candidates must:

1. have late stage limited life expectancy cancer;
2. have at least one (1) child age between the ages of three(3) and eighteen (18). Only one child must meet the age requirement;
3. have a life expectancy over two (2) months;
4. be referred by an approved Referral Agency or treating oncologist.
5. all referrals must not have previously participated in an adult dream, wish or any other similar program.

Part I- Instructions: Please fully complete Sections I – VII. To be eligible, all forms must be fully completed, including all required signatures. Referrals will not be contacted until the Memory Opportunity referral package, including all forms, are fully completed and returned.

Please also mail or fax the completed referral package to:

JAJF
3282 Northside Pkwy., N.W
Suite 100
Atlanta, GA 30327
Fax #: (404) 920-2139

Should you have any questions, please do not hesitate to contact the Executive Director, **Heidi Cohen**, at **(404) 537-5254**.

Thank you for helping JAJF to provide a Memory Opportunity (“WOW!” Experience™) for your referral candidate and his/her family.



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Section I
Referral Information Form

Instructions: Please input information regarding the referral candidate family.

Referral/Patient Information: (As listed on your driver's License)

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: _____ SS#: _____

Spouse Name: Last Name: _____ First Name: _____ M.I.: _____

Spouse Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____ - _____

Work: (____) _____ - _____

Cell Phone: (____) _____ - _____

Spouse's Cell: (____) _____ - _____

Fax: (____) _____ - _____

E-mail Address: _____ Spouse E-mail: _____

Names of Children, Dates of Birth and Gender, :

Name: _____ Date of Birth: _____ Gender: M/F

Name: _____ Date of Birth: _____ Gender: M/F

Name: _____ Date of Birth: _____ Gender: M/F

Name: _____ Date of Birth: _____ Gender: M/F

Emergency Contact Information:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____ - _____

Work: (____) _____ - _____

Cell Phone: (____) _____ - _____

E-mail Address: _____



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Section II

Demographic and Statistical Information Form

Instructions: Please input requested demographic and statistical information. This section is required to be completed for statistical purposes as The National Cancer Institute and other leading national oncology organizations may track the short and long term benefits of the JAJF program. Please circle one (1) answer or write in an answer, as appropriate.

Ethnicity of Referral:

- African American
- Asian
- Caucasian
- Hispanic
- Native American
- Other

Total Family Income of Referral Family:

- Less than (<) \$25,000
- \$25,001-\$50,000
- \$50,001-\$100,000
- \$100,001-\$150,000
- \$150,001-\$200,000
- Greater than (>) \$200,000

Patient's Occupation: _____

Patient's Employer: _____

Spouse's Occupation: _____

Spouse's Employer: _____



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Section III

Oncology Referral Agent Information Form

Instructions: The referring oncology staff person (“Referral Agent”) should complete this form to provide JAJF necessary contact information.

Contact Information: (Person at oncology office we call, should we need additional information.)

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (_____) _____ - _____

Work: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

E-mail Address: _____

Name of Hospital/Cancer/Oncology Center/Organization:

Address: _____

City: _____ State: _____ Zip code: _____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

Website Address: www. _____

E-mail Address: _____



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Section IV

Medical Information Form

Instructions: This form is to be completed by the referral's treating physician. Where appropriate please fill in an answer or mark [X] in the appropriate box.

Physician's Name: _____

Hospital/Center/Organization Affiliation: _____

Patient's Name: _____

Diagnosis: _____

1. Time Frame of Memory Opportunity

- within 1-2 months
- within 3-4 months
- within 5-6 months

2. Activity Level Permitted

- Sedentary
- Moderate
- No Limitations

3. Travel Limitations:

Can travel out of home city? Yes No

Can travel for several days? Yes No

Can travel by car? Yes No

Please specify maximum duration of travel. _____

Can fly via commercial airlines? Yes No

Can fly via private airplane? Yes No

Requires ADA Room? Yes No

Limit Exposure to Light? Yes No

Please explain any limitations, activity restrictions or other specials needs: _____



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Section V

Physician's Statement

I hereby acknowledge that Section IV has been completed to the best of my knowledge and hereby permit _____ ("Recipient") to participate in the Memory Opportunity offered by The Jack and Jill Late Stage Cancer Foundation, Inc. and acknowledge that Recipient may participate despite the medical limitations listed in Section IV.

Physician's Signature: _____ **Date:** _____

Physician's Contact Information

Last Name: _____ **First Name:** _____ **M.I.:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home Phone: (_____) _____ - _____

Work: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

E-mail Address: _____



SECTION VI
HIPAA RELEASE FORM

TO: _____
(Physician)

(Physician's Address)

(Physician's Telephone Number)

RE: _____
(Patient - Print Name Legibly)

(Patient's Date of Birth)

I authorize the use and disclosure to The Jack and Jill Late Stage Cancer Foundation ("JAJF") of protected health information about Patient as described below:

Information that may be used/disclosed: All protected health information relating to Physician's assessments of: (a) whether Patient is medically eligible for JAJF's services; and (b) if so, whether his/her desired Memory Opportunity is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to JAJF's forms that JAJF may require, including forms relating to Patient's medical eligibility, the requested Memory Opportunity and medical consideration relating thereto.

Persons authorized to use/discard the information: The Physician identified above, as well as his/her authorized representatives.

Persons authorized to receive the information: Employees or other authorized representatives of JAJF.

Purpose for which information will be used/disclosed: To enable JAJF to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to have a Memory Opportunity granted by JAJF and, if so, whether the requested Memory Opportunity is medically appropriate; and (b) pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient's Memory Opportunity has been granted by JAJF or a final determination has been made that Patient is not eligible to receive a Memory Opportunity.

Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:

- a. I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization;
- b. I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulation, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Patient Name

Patient Signature

Date

Patient Representative

Patient Representative Signature

Date



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Section VII

Referral Candidate's Statement

I hereby warrant and represent that the information provided in Sections I -VII of the Memory Opportunity Referral Package is accurate. I consent to be contacted by The Jack and Jill Late Stage Cancer Foundation, Inc. ("JAJF"), via phone, fax, mail and/or e-mail at the numbers/addresses provided by me or my Referral Agent in regard to a Memory Opportunity ("WOW! Experience) offered by JAJF.

Referral Candidate Signature: _____

Print Name: _____

Date: _____