

Program Overview

The AstraZeneca Hope Lodge Center in Boston, a program of the American Cancer Society, provides a safe, supportive, and self-sufficient home away from home for those in active outpatient cancer treatment. We offer 40 private, 3-room guest suites and shuttle service to and from area treatment centers at no cost to our guests. There is no income or financial requirement to stay at the Lodge. For more information, and to see a virtual tour of our state-of-the-art facility, visit us online at www.cancer.org/hopelodgeboston.

Criteria

Given the high demand for our free services, guests must meet the following in order to be considered for free housing during requested dates:

- ❖ Be in active outpatient treatment for cancer and permanently reside 40 miles or more away from their treatment facility
- ❖ Be able to care for themselves, navigate the building, and evacuate the building in case of an emergency
- ❖ Have a *projected* start and end date for their treatment
- ❖ Arrive and depart within 24 hours of their first and last medical appointments with a minimum stay of 3 consecutive nights
- ❖ Provide the Hope Lodge with proof of a permanent residence upon arrival
- ❖ Understand English (defined as a basic understanding of the language that will enable him/her to read and follow instructions in case of an emergency, as well as be able to navigate the facility safely). If the patient does not understand English, he/she should be accompanied by a caregiver who does understand English.
- ❖ Not be on parole for a felony charge, or have been convicted of a felony in the past 5 years

It is highly recommended that all patients have a caregiver staying with them while at the Lodge. Caregivers must be able to provide assistance to patient as needed.

The Lodge is not a medical facility. There are no nurses or doctors on-site and no medical services are provided.

Referral Process

To inquire about room availability, or for questions regarding our program, call 617-396-5511. To make a referral:

- 1) Fax a Housing Referral Form (the following 1 page), complete with a physician's signature, to 617-278-1585. *All requested information must be complete or the referral will not be processed.* A received referral confirmation will be emailed to the referring party and the patient's email addresses, as indicated on the form, generally within 1 business day.
- 2) The Lodge will contact the patient or caregiver directly (not the referring provider, if different) within 2 business days to discuss room availability and complete a brief telephone interview verifying the information contained in the referral and appropriateness of fit of the guest/caregiver with our services. At this point in the process, it is the guest/caregivers' responsibility (not the referring party) to follow-up directly with the Lodge regarding issues or changes relating to the their referral.
- 3) If a guest reservation is confirmed, or if there is no room availability and a guest is placed on a waiting list, an acknowledgement will be emailed to the patient and/or caregiver within 2 business days of the telephone interview. The referring party will be included on this email to provide them with an updated status of the referral.

**The completed referral form on the following page should be faxed to 617-278-1585.
You may call 617-396-5511 should you have any questions.
More information (including a virtual tour) can be found at www.cancer.org/hopelodgeboston.**



AstraZeneca Hope Lodge Center in Boston

125 South Huntington Ave., Jamaica Plain, MA 02130

617-396-5500 (Phone) 617-278-1585 (Fax)

AstraZeneca Hope Lodge

Housing Referral Form: Complete ALL Fields

First time Guest: _____
Returning Guest: _____

PATIENT INFORMATION

Personal

DOB: _____ Gender: _____

Name: _____ Daytime Phone: _____

Home Address: _____ Evening Phone: _____

City/ST/Zip: _____ Cell Phone: _____

Ethnicity: _____ Type of Insurance: _____

Primary/Secondary

Languages: _____ Email: _____

Medical Information

Date of Diagnosis: _____

Diagnosis/Stage: _____ Treatments/week: _____

Treatment Facility: _____ Type of Treatment: _____

Treatment Start Date: _____ End Date: _____

Is the patient enrolled in a clinical trial? Yes No Type/Length _____ Is this a transplant patient? Yes No

Referring Party

Referring Party's Name: _____ Phone: _____

Email: _____ Pager: _____

Treating Physician: _____ Phone/Pager: _____

I explained the American Cancer Society (ACS) Hope Lodge services to the patient, and I have obtained express authorization to disclosure this information to the ACS for purposes of a applicable follow up and referral to Hope Lodge. _____ (please initial)

Other

Does the patient have any infectious diseases? Yes No

Is the patient bringing a caregiver? Yes No

Does the patient understand English? Yes No

How did the patient hear about Hope Lodge? _____

Does the caregiver understand English? Yes No

Has the patient or caregiver ever been convicted of a crime? Yes No

Any special needs? _____

If yes, what was the type of crime and when convicted? _____

CAREGIVER INFORMATION

Name: _____ Relationship to Patient: _____

Address: _____ DOB: _____

City/Zip: _____ Email: _____

Phone: _____ Cell Phone: _____

Please give Emergency Contact information if other than listed above:

(Name)

(Relationship)

(Phone)

TREATING PHYSICIAN

I affirm that to the best of my knowledge, the patient listed above does not have any infectious disease symptoms (e.g., upper respiratory infection, viral rashes/skin rashes, tuberculosis, influenza, measles, etc.). I have reviewed the eligibility requirements with the patient, and I affirm that he/she meets all of these.

Treating physician (please print)

Signature/Date