American Cancer Society Hope Lodge Lexington - Lodging Request Form

1500 College Way, Lexington KY 40502. Please call 859-260-8300 with any questions.

Please complete (print) ALL fields and fax form to 859-260-8302 or email form to hopelodgelexingtonky@cancer.org

The American Cancer Society cares about your privacy and that of your patient's, and protects how we use this information. To view our full privacy policy or if you have any questions, please call us at 1-800-227-2345 or visit us online at cancer.org and click on the 'privacy' link at the bottom of the page.

LODGING INFORMATION

Requested Arrival Date: mm/dd/yyyy Anticipated Departure Date: mm/dd/yyyy Number of Nights Requested: _____

Treatment Facility: Select Treatment Facility Patient ID# *(if used by referring party)* : _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: mm/dd/yyyy Gender: Select

Home Address: _____ Diagnosis / Cancer site: _____

City / State / Zip: _____ Date of Diagnosis: mm/dd/yyyy

County: _____ Type of Cancer Treatment: _____

Home Phone: _____ Treatments per week: _____

Cell Phone: _____ Other Special Needs: _____

Email Address: _____

Caregiver's Name: _____ Phone: _____ Relation to Patient: _____

Emergency Contact: _____ Phone: _____ Relation to Patient: _____

ELIGIBILITY CRITERIA

Note: you may tab over, and hit enter to answer yes or no

	Patient		Caregiver	
1. Does the guest understand English?	☐ Yes	☐ No	☐ Yes	☐ No
2. Does the guest have a service animal?	☐ Yes	☐ No	☐ Yes	☐ No
3. Does the guest need a wheelchair-accessible room?	☐ Yes	☐ No	☐ Yes	☐ No
4. Does the guest have any infectious diseases or infectious-disease symptoms?	☐ Yes	☐ No	☐ Yes	☐ No
5. Has the guest ever been convicted of a crime of violence, crime of domestic violence, crime against a child, crime of theft, or a crime involving illegal drugs?	☐ Yes	☐ No	☐ Yes	☐ No
6. Does the guest have a civil protection order against them?	☐ Yes	☐ No	☐ Yes	☐ No
7. Is the guest on probation or parole?	☐ Yes	☐ No	☐ Yes	☐ No
8. Has the guest been required to register on the State or National Sex Offender Registry?	☐ Yes	☐ No	☐ Yes	☐ No

REFERRING PARTY INFORMATION

Treating Physician: _____ Department: _____

Referring Professional: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

As the referring source, I have explained the American Cancer Society guidelines and affirm that, to the best of my knowledge, the patient listed above does not have any communicable or infectious diseases or infectious-disease symptoms. I have reviewed the eligibility requirements with the patient, and I affirm that he/she meets all of these. I explained the American Cancer Society Hope Lodge services to the patient, and I have obtained express authorization to disclose this information to the American Cancer Society for purposes of applicable follow up and referral to the Hope Lodge facility.

_____ mm/dd/yyyy

Treating physician or referring professional's signature **Date**

OTHER PATIENT INFORMATION

Optional Patient Information (for recording purposes only)

Ethnicity: Select Ethnicity

Type of Insurance: ☐ Private ☐ Medicaid ☐ Medicare ☐ Insurance Exchange ☐ Uninsured ☐ Other

---------- **To be signed by Patient upon arrival at the Hope Lodge** ----------

I have reviewed and confirmed the accuracy of the data provided in the Patient Information and Eligibility Criteria sections on this form.

_____ _____

Patient signature **Date**

FOR HOPE LODGE STAFF USE ONLY

New Guest ☐ Return Guest ☐ Actual Arrival Date: _____ Actual Departure Date: _____

Entered into Epitome: _____ Treatment Facility ACS ID: _____ Number of Nights Provided: _____

Service Request (circle one): **Met** **Partially Met** **Not Met** Not Met Reason: ☐ No Space ☐ Patient Not Eligible

☐ Canceled by Patient ☐ Refer to Patient Services/Hotel Partners Program: _____