CHAT PROGRAM
Connecting Hope, Assistance & Treatment

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S
Center for Community Health and Health Equity

Today's Date ___/___/_____

Please complete all pages.

Applicant Information

First Name: _____ Middle Initial ____ Last Name _____ Date of Birth ___/___/_____

Address: _____ City_____ State _____ Zip Code _____

(Please circle)
Home Phone: _____ Work or Cell Phone: _____ Email: _____

Race/ Ethnicity ***(Please complete page 5)***

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Transgender, Female to Male
- ☐ Transgender, Male to Female
- ☐ Other: _____

How well do you speak English?
- ☐ Very well or well
- ☐ Not well
- ☐ Not at all

What is your primary language?
_____

Year patient was diagnosed with breast cancer _____ Date of most recent breast surgery, if applicable_____

Income Information

Number of people in your household _____

Total annual income $ _____ ☐ Individual ☐ Family

Proof of Income

Do you have a copy of your federal income tax return from last year?

☐ **Yes** Please send us a copy of last year's **Federal Income Tax Returns** for yourself, your spouse or significant other	☐ **No** If you didn't file a federal income tax return last year, you must send a copy of: ☐ All income statements from jobs for yourself and your spouse or significant other (**W2** or **1099, or three consecutive pay stubs**) **OR** ☐ Statement of benefits from Social Security, TANF, Short/long term disability, unemployment or letter of financial support

Insurance Information

Does patient have insurance? ☐ **Yes** ☐ **No** **If yes, what type** _____ ***(Please provide copy of card)***

Do you have any form of prescription drug coverage?

☐ Employer furnished or private drug coverage ☐ State assistance program for medicine ☐ Medicaid
☐ Other ☐ Medicare ☐ None

Resource Request Information

- ☐ Tamoxifen/ Arimidex/ Femara
- ☐ Compression sleeve
- ☐ Breast prosthesis
- ☐ Wig
- ☐ Childcare
- ☐ Counseling
- ☐ Nutrition Resources
- ☐ Transportation
  - ☐ Reimbursement for parking
  - ☐ MBTA The Ride – Rider #_____ If pending, date of application_____
  - ☐ MBTA Charlie Card or Commuter Rail Pass
  - ☐ Cab Voucher
- ☐ Other (please specify)_____

Individual making referral or referral source (How did you hear about the CHAT Program) (REQUIRED)

(Please print clearly)

Name _____ Agency/ Organization _____

Telephone _____Fax_____ Email _____

☐ Self referral ☐ Internet search ☐ American Cancer Society

Vendor Information

(Please print clearly)

Since the CHAT Program works directly with vendors, and does not provide money directly to patients, please provide information of vendor who will provide service. All effort will be made to meet your request, however CHAT works with preferred vendors.

Name of Vendor _____ Phone _____ Fax_____

Address _____City/State/Zip code _____

Please complete this section so we can have a better understanding of your needs.

Generally speaking, when you need comfort where do you turn, or what do you to help you feel better, relaxed or to simply listen to your concerns? (Please explain)

_____
_____
_____
_____
_____

Since your diagnosis, how have you stayed mentally and physically healthy? (Please check all that apply)

- ☐ Support from family
- ☐ Support from friends
- ☐ Support from doctors/ nurses
- ☐ Support from social worker/ patient navigator
- ☐ Counseling, acupuncture, meditation or massage therapy
- ☐ Support group
- ☐ Healthier diet
- ☐ Regular exercise
- ☐ Other: please specify _____

What kind of lifestyle changes have you made since your diagnosis? (Please check all that apply)

- ☐ Healthier diet
- ☐ Regular exercise
- ☐ Regular visits with medical providers
- ☐ Quit smoking or smoke less
- ☐ Stop drinking alcohol or drink less
- ☐ Counseling, acupuncture, meditation or massage therapy
- ☐ Joined a support group
- ☐ Other: please specify _____

Which lifestyle change made you the happiest? (Please check all that apply)

- ☐ Healthier diet
- ☐ Regular exercise
- ☐ Regular visits with medical provider
- ☐ Quit smoking or smoke less
- ☐ Stop drinking alcohol or drink less
- ☐ Counseling, acupuncture, meditation or massage therapy
- ☐ Joining a support group
- ☐ Other: please specify _____

What is/ was the biggest burden you face/d during treatment? (Please check all that apply)

- ☐ Food
- ☐ Housing/ Rent
- ☐ Transportation
- ☐ Medical appointments
- ☐ Medication
- ☐ Cancer related supplies
    - o Breast prosthesis/ bras
    - o Compression Garments
    - o Other_____
- ☐ Childcare
- ☐ Other (please describe):_____

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office.

You have the right to restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment, or health care operations.

2) The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.

3) The practice reserves the right to change the notice of privacy practices.

4) The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.

5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Patient Name: _____ **Signature** _____ Date ___/___/_____

(Please print patient name or representative)

THIS SECTION FOR OFFICE USE ONLY- DO NOT COMPLETE

Date received _____ ☐ Entered in CHAT database ☐ Mailed CHAT intro letter

Application: Approved _____ Denied _____

Reason for denial: ☐ POI – Over limit ☐ POI – Failure to provide adequate POI ☐ Pending for additional information

Before you mail this application

- ☐ Attached a copy of last year's federal income tax returns for yourself, your spouse/ significant other (or other proof of income)
- ☐ Attach copy of prescription (if requesting resources for medication, compression garment or breast prosthesis, bra)
- ☐ Attach appointment schedule (if requesting resources for transportation)
- ☐ Copy of insurance card or MA REVS Form

Mail or fax completed application to

CHAT Program
Center for Community Health and Health Equity
801 Massachusetts Avenue, 5th Floor
Boston, MA 02118
Phone: (617) 582-0160 Fax: (617) 582 – 0190

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL

Brigham and Women's Hospital, in partnership with the State of Massachusetts and the Boston Public Health Commission, is interested in learning more about differences in health. We want to make sure that all our patients get the best care possible, regardless of their race or ethnic background. We would like you to tell us your race or ethnicity so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. The collection of this information is confidential and voluntary. It will not affect the delivery of services nor ever be used to discriminate in the provision of services.

I. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACE? (*You can choose more than one)*
Race is a category that refers to a group of people with shared physical characteristics.

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Caucasian or White
- ☐ Other Race (please specify): _____
- ☐ Declined (I do not wish to provide)
- ☐ Unknown

II. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNICITY? (*You can choose more than one)*
Ethnicity refers to a group with a shared cultural heritage which means a shared language, history, religion, traditions/customs, and/or geographic region of origin.
to provide)

- ☐ African American
- ☐ African-Ethiopian
- ☐ African-Ghanaian
- ☐ African-Liberian
- ☐ African-Nigerian
- ☐ African-Sierra Leonean
- ☐ African-Somalian
- ☐ American
- ☐ Asian Indian
- ☐ Asian-Bangladeshi
- ☐ Asian-Bhutanese
- ☐ Asian-Burmese
- ☐ Asian-Hmong
- ☐ Asian-Indonesian
- ☐ Asian-Iwo Jimian
- ☐ Asian-Madagascar
- ☐ Asian-Maldivian
- ☐ Asian-Nepalese
- ☐ Asian-Okinawan
- ☐ Asian-Pakistani
- ☐ Asian-Singaporean
- ☐ Asian-Sri Lankan
- ☐ Asian-Taiwanese
- ☐ Asian-Thai
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Island-Barbadian
- ☐ Caribbean Island-Dominica Islander
- ☐ Caribbean Island-Jamaican
- ☐ Caribbean Island-Tobagonian
- ☐ Caribbean Island-Trinidadian
- ☐ Caribbean Island-West Indian
- ☐ Central American-Belizean
- ☐ Central American-Costa Rican
- ☐ Central American-Indian
- ☐ Central American-Nicaraguan
- ☐ Central American-Panamanian
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ Eastern European-Albanian
- ☐ Eastern European-Armenian
- ☐ Eastern European-Bosnian
- ☐ Eastern European-Croatian
- ☐ Eastern European-Polish
- ☐ Eastern European-Ukrainian
- ☐ European-English
- ☐ European-French
- ☐ European-German
- ☐ European-Greek
- ☐ European-Irish
- ☐ European-Italian
- ☐ European-Scottish
- ☐ European-Spanish
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicano
- ☐ Middle Eastern-Afghanistani
- ☐ Middle Eastern-Assyrian
- ☐ Middle Eastern-Egyptian
- ☐ Middle Eastern-Iranian
- ☐ Middle Eastern-Iraqi
- ☐ Middle Eastern-Israeli
- ☐ Middle Eastern-Lebanese
- ☐ Middle Eastern-Palestinian
- ☐ Middle Eastern-Syrian
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ South American Indian
- ☐ South American-Argentinian
- ☐ South American-Bolivian
- ☐ South American-Chilean
- ☐ South American-Criollo
- ☐ South American-Ecuadorian
- ☐ South American-Guyanan
- ☐ South American-Paraguayan
- ☐ South American-Peruvian
- ☐ South American-Uruguayan
- ☐ South American-Venezuelan
- ☐ Vietnamese
- ☐ Other; please specify: _____