



ANNUAL VISITOR FORM

The Cancer Support Community Los Angeles gathers information about every member to help us better understand who comes to our programs. All personal information will be kept confidential. Since we are a non-profit organization that does not charge for our services, we rely solely on donations to underwrite our programs and we need the following information to help us secure funding. The information provided to funders will be only in terms of combined demographic data of all members with no identifying information. Your answers to these questions will, in no way, affect your ability to access all programs at the Cancer Support Community Los Angeles at no charge. PLEASE PRINT CLEARLY. THANK YOU!

Date: _____ Today I am attending: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (check preferred): (HM)() _____ (Cell)() _____ (E-Mail) _____

May we use your mail or email address to share upcoming programs and special events? Mail: Yes No Email: Yes No

May we leave you a voicemail from CSCLA? Yes No

Emergency Contact: _____ Relationship: _____

Phone: (HM) () _____ (WK)() _____ (Cell) () _____

Do you have children under the age of 18 years? Yes No

If yes, what are their names and age(s): _____

How did you hear about CSCLA? Doctor Nurse Social Worker Friend/Family Newspaper
 TV/Radio Internet CSCLA Staff/volunteer Other _____

If you were referred by a health care professional, please complete the following:

Name of person who referred you _____ Hospital/Office: _____

PLEASE COMPLETE THE FOLLOWING ABOUT YOURSELF:

I am registering as a: (check one) Person with Cancer Support Person (family, friend, or caregiver) Person in Bereavement
 Both Person with Cancer and Support Person Healthcare professional

Date of Birth: _____

If you are a support person, what is the name of the person with cancer that you are here to support? _____

PLEASE COMPLETE THE FOLLOWING FOR YOURSELF OR FOR THE PERSON YOU ARE HERE TO SUPPORT:

Cancer Diagnosis: _____ Date Diagnosed: _____

Hospital: Cedars-Sinai Cedars: Tower Saint John's UCLA USC CHLA Kaiser: Sunset Kaiser: West LA
 Other _____

The following questions are optional and are used to help us better understand whom we are serving, and any groups that may be underserved.

Marital status: Single Coupled Domestic partnership Married Divorced Widowed

Gender identity: Man Woman Transman Transwoman Nonbinary Other: _____

Sexual orientation: Bisexual Gay Lesbian Straight Other: _____

Race/Ethnicity: White (non-Hispanic) Black/African American (Not Hispanic) White- Hispanic Black – Hispanic
 American Indian/Alaska Native/ First Nations Asian/Pacific Islander Multi-Racial Other _____

Insurance: Medicare only Medicare + private Medicaid/MediCal Private Insurance Uninsured

Employment Status: Employed full-time or part-time On medical leave Disabled Not employed Student Retired

Annual Household Income: under \$25,000 \$25,000-49,999 \$50,000-74,999 \$75,000-99,999 over \$100,000

Thank you!