Fighting Funds Enrollment Form

Davids Fight.org
PO Box 65265
West Des Moines, IA 50265
FAX: (515) 864-0054

1. All questions must be answered. Please print.
2. Read all pages. Initial and date page 1. Sign and date page 2.
3. Fax, mail, or e-mail via attachment.

First Name	Initial	Last Name	Maiden Name (if applicable)

Address	City	State	Zip

Birthdate month / day / year	Age	Gender M / F	Social Security #

E-mail Address

Home Phone	Alt. Phone

Contact Person: _____

Relationship: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

How did you hear about the program?

☐ Doctor ☐ Healthcare Provider
☐ Family ☐ Mailer/Flyer
☐ Television ☐ Newspaper
☐ Billboard ☐ Website
☐ Friends ☐ Radio
☐ Community Event

What race or ethnicity are you?

☐ American Indian Tribe _____
☐ Black/African American ☐ Hispanic/Mexican American
☐ White ☐ Asian
☐ Pacific Islander ☐ Latino/Latina
☐ Other _____

Country of Origin _____

What is your primary language?

☐ English ☐ Vietnamese
☐ Spanish ☐ Other _____

Highest grade in school you completed: circle one **0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+**

I will be required to show proof that my income is within the income guidelines when I am contacted by Davids Fight.org
If I am found to be over the income guidelines, I will be responsible for my bills.

What is your household income before taxes? Yearly Income: $ _____	How many people live on this income?
Do you have Health Insurance Coverage? Yes or No	Deductible: $_____
Insurance Provider: _____	Out of Pocket Maximum: $_____

Family History:

How many family members (parents, brothers, sisters, children) have been told they have colorectal cancer? *(circle one)*
0 1 2 3+ Don't know

How many of those family members with colorectal cancer were under the age of 60? *(circle one)*
0 1 2 3+ Don't know

How many family members (parents, brothers, sisters, children) have been told they have colon polyps? *(circle one)*
0 1 2 3+ Don't know

How many of those family members with polyps were under the age of 50? *(circle one)*
0 1 2 3+ Don't know

How many family members (parents, brothers, sisters, children) have been told they have other types of cancer? *(circle one)*
0 1 2 3+ Don't know

What kind of cancer did they have? _____

Initial _____ **Date** _____

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Have you ever had any of the following tests?:

Fecal Occult Blood Test (FOBT)	☐ Yes	☐ No	☐ Don't Know	**Date** _____/_____/_____
Colonoscopy	☐ Yes	☐ No	☐ Don't Know	**Date** _____/_____/_____
Simoidoscopy	☐ Yes	☐ No	☐ Don't Know	**Date** _____/_____/_____
Double Contrast Barium Enema (DCBE)	☐ Yes	☐ No	☐ Don't Know	**Date** _____/_____/_____

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Crohns Disease	☐ Yes	☐ No	☐ Don't Know
Familial Adenomatous Polyposis (FAP)	☐ Yes	☐ No	☐ Don't Know
hereditary Non Polyposis Colorectal Cancer (HNPCC)	☐ Yes	☐ No	☐ Don't Know
Inflammatory Bowel Disease (IBD)	☐ Yes	☐ No	☐ Don't Know
Ulcerative Colitis	☐ Yes	☐ No	☐ Don't Know

Are you currently under a doctor's care for any of the above conditions?	☐ Yes	☐ No	☐ Don't Know
Within the last 30 days have you had bleeding from the rectum?	☐ Yes	☐ No	☐ Don't Know
Have you ever been told that you have had polyps in the colon?	☐ Yes	☐ No	☐ Don't Know
Have you ever been told you have had colon or rectal cancer?	☐ Yes	☐ No	☐ Don't Know

Who is your primary doctor? _____

Clinic: _____ City: _____ Phone: ( ) _____

Do you have a Dr. preference for your screening? _____

Dr./Clinic: _____ City: _____ Phone: ( ) _____

- I understand that Davids Fight.org (DF) will look at my health history and help me determine what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may receive screening and/or health education materials.
- I know that DF will help cover the cost of colonoscopy if DF finds that it is the best type of colon cancer screening test for me or follow up after a positive Fecal Occult Blood Test (FOBT).
- If I receive a colonoscopy through DF, I understand that I will be asked to pay 10% of the cost or as much as I am able.
- I understand that my payments will help others with colonoscopy costs through DF.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by DF.
- DF may remind me when it is time for me to go to my screening exams and send me information by mail to help me learn more about my health. I will follow through on any advice my doctor may give me.
- **I understand that DF does not pay for treatment if diagnosed with colon cancer. DF staff will assist me in finding the most appropriate treatment resources.**
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal sceening, diagnostic tests, and/or treatment services to DF.
- I understand that DF may follow up with my primary care doctor if my past medical records need to be reviewed to determine the best colon cancer screening for me.
- My name, address, and/or other personal information will be used only by DF. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by DF and/or The Centers for Disease Control and Prevention for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.
- To assist me in making the best healthcare decisions, DF may share clinical and other healthcare information including lab results and health history with my healthcare providers.

Signature Date

Informed Consent and Release of Medical Information

1) Read this page.
2) Keep this page for your records.
3) Fax, mail, or e-mail via attachment. (See bottom of this page for contact information.)

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Signature Date

Print Name Date of Birth

Davids Fight.org – PO Box 65265 – West Des Moines, IA 50265
FAX: (515) 864-0054 – E-Mail: david@davidsfight.org

Include a copy of your most recent tax return.

Send all documents to:

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