Eisai Magnolia *Meals at Home*®

Magnolia® – Partners Along the Patient Journey embodies the Eisai *human health care* (*hhc)* mission of placing patients at the center of everything we do. Eisai's *hhc* mission states that "We give first thought to patients and their families, and to helping increase the benefits health care provides."

Magnolia *Meals at Home*® was developed to help meet the evolving needs of patients living with cancer and their families. Through a partnership with Cancer*Care*®, Cancer Support Community®, and Meals on Wheels America, Magnolia *Meals at Home* provides meals that are nutritionally geared toward patients living with cancer and their families. The goal of the program is to help ease the stress of daily living, so that patients can enjoy shared moments with loved ones.

- Magnolia *Meals at Home* is currently available in and around Nutley, NJ, Cambridge, MA and New Haven, CT (as well as areas in New York, New Hampshire and Boston, MA).
- Patients who live within a predefined area of approximately 25 miles of these locations are eligible to enroll
  - —They may sign up to participate for up to 2 months of meal deliveries
  - —There are no requirements for financial need to participate
- Meals will be delivered once a month and will include up to 10 meals for the patient and up to 10 meals for their family members, if requested by the participant

The enrollment and delivery process is simple and direct

- Patient's name and relevant contact information is provided by Cancer*Care* or Cancer Support Community to Meals on Wheels through the online enrollment system
- Meals on Wheels will call the patient to schedule a delivery
- Someone at the delivery address must be home to receive the meals
- Meals will be delivered by Meals on Wheels and/or by an Eisai volunteer
- An optional survey may be included with meal deliveries or will be mailed separately to you

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☐ **YES,** patient is interested in participating. See completed form on reverse side.

Referring Advocacy Organization
(Please check one)

☐ Cancer*Care* ☐ Cancer Support Community

Cancer*Care*
Kathy Nugent, LCSW
One Kalisa Way, Suite 205,
Paramus, NJ 07652
Phone: (201) 301–6809
Toll-free: (800) 813–HOPE ext. 6809
Fax: (201) 444–0978
knugent@cancercare.org

Cancer Support Community
Jane E. Brown
734 15th Street, NW, Suite 300,
Washington, DC 20005
Phone: (617) 733–5848
Toll-free: (888) 793–9355
jane@cancersupportcommunity.org

Eisai

hhc
human health care

magnolia
meals at home®

Application for Eisai Magnolia *Meals at Home*®

Date _____

Patient name _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Secondary contact

Name _____ Phone _____

Relationship to patient _____

Week delivery should begin

_____

☐ **Include meals for the family**

1. Primary caregiver relationship to patient ☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Friend

☐ Private nurse/health care professional ☐ Other_____

2. Referring social worker/health care professional contact information

Name _____ Phone _____ Email_____

3. Patient information Gender of patient ☐ Female ☐ Male Date of birth _____

Date of diagnosis _____ Primary diagnosis _____ Current stage of cancer _____

☐ New diagnosis ☐ Recurrence Is patient in active treatment? ☐ Yes ☐ No

Please indicate type of treatment(s) received in the past 3 months (check all that apply)

☐ Chemotherapy ☐ Hormone therapy ☐ Targeted therapy ☐ Radiation ☐ Surgery ☐ Other _____

4. Verification of patient health status ☐ Physician note attached ☐ Contact physician directly

Physician's name _____ Phone _____

5. How would members of the household best like to be contacted?

☐ Phone _____ ☐ Email _____ ☐ Other _____

6. How did the patient hear about Magnolia *Meals at Home*?

☐ Advocacy organization ☐ News or other publication ☐ Physician ☐ Nurse ☐ Other _____

7. Patient consent

I understand the terms for participation in the Magnolia *Meals at Home* Program (the "Program") as described above. I hereby authorize my health care providers, including my doctors, nurses, and any others who provide me with health care services, to disclose to the partners of Program, including Cancer*Care*, Cancer Support Community, Meals on Wheels America and Eisai Inc. (including its employees, agents, and representatives), as well as to Eisai's vendors and affiliates, information that is identifiable to me relating to my health. I authorize the disclosure of this information, and the use of the information by the aforementioned Program partners and related entities, for purposes of the Program's administration and provision of services and for communicating with me and my caregivers about the Program. I understand that, once my personal health information is so disclosed, its confidentiality may no longer be protected under federal privacy law and it could be re-disclosed to others. I understand that by signing this form I am covered by HIPAA.

I am aware that I am not required to sign this authorization in order to receive treatment from my health care providers or to be enrolled in a health plan or be eligible for health plan benefits. The Program is not meant to provide medical advice. I will consult with my health care providers as to my personal medical needs prior to participating in the Program.

I understand that I may terminate my enrollment, receive a copy of this form, or revoke this authorization at any time by providing written notice to either (1) Kathy Nugent, LCSW, CancerCare, One Kalisa Way, Suite 205, Paramus, New Jersey 07652, or (2) Jane E. Brown, Cancer Support Community, 734 15th Street, NW, Suite 300, Washington, DC 20005. I also understand, however, that any such revocation will not affect uses and disclosures of my health information made prior to the revocation. Unless and until I withdraw this authorization, it will remain valid and effective until seven years after the date of signing below.

I also understand that Eisai reserves the right to terminate the Program at any time without notice.

Patient name _____ Signature _____ Date_____

Name of legal representative _____ Signature _____ Date_____

Authorized as [legal guardian or other] to act on behalf of [name of patient]

*There are no requirements for financial need to participate in this program.

†Certain types of cancer may have specific dietary restrictions. Speak with your doctor before starting the Magnolia Meals at Home program to make sure the meals are right for you.

CANCERcare Help and Hope

CANCER SUPPORT COMMUNITY A Global Network of Education and Hope

MEALS ON WHEELS AMERICA