



**THE CENTER FOR PATIENT PARTNERSHIPS**  
AT THE UNIVERSITY OF WISCONSIN - MADISON

## Application for Patient Advocacy Services

Our primary mission is educating future professionals in health advocacy and patient-centered care. Through this educational process, we provide patient advocacy services to individuals with life threatening and serious chronic illnesses. We make every effort to assist individuals in an efficient and effective manner. As a small educational center, clients often must wait for services. We do our best to prioritize urgent cases. If we cannot take your case, we provide referrals to community resources whenever possible.

**Important note:** To complete this form, please use the latest version of Adobe Acrobat or Adobe Reader, available at <http://get.adobe.com/reader/>

### Options for submitting completed application:

<p style="text-align: center;"><b>Save &amp; Email* to:</b> <a href="mailto:cppadvocacy@law.wisc.edu">cppadvocacy@law.wisc.edu</a></p> <p style="text-align: center;"><i>*Clicking the "Submit" button on the last page should do this.</i></p>	<p style="text-align: center;"><b>Print &amp; Mail:</b> CPP Intake Center for Patient Partnerships 975 Bascom Mall, Suite 4311 Madison, WI 53706-1399</p>
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**Please fill out this form as completely as possible.** Upon receipt, an advocate will contact you within a few days to discuss your application. If you have not heard back within that time frame, please call 608-890-0321 or email [cppadvocacy@law.wisc.edu](mailto:cppadvocacy@law.wisc.edu).

<b>Today's Date</b>

### Contact Information

<b>Are you the patient? (check one)</b>		<b>If you are not the patient, you are: (check one)</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spouse/Partner	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Friend
	<input type="checkbox"/> Health Professional	<input type="checkbox"/> Other _____			
<b>Name of Applicant</b>					
<b>Street address</b>		<b>City</b>		<b>State</b>	<b>Zip code</b>
<b>Land phone</b>	<input type="checkbox"/> home <input type="checkbox"/> work	<b>Mobile phone</b>		<b>Best time to call</b>	
<b>Email address</b>			<b>How did you learn about the Center?</b>		

## Health Information

Primary diagnosis	Date of initial diagnosis
Current symptoms	Additional health issues

## Advocacy Needs

Explain why you are contacting the Center and what services you are seeking.

If we could provide some immediate information, tools, or resources what would they be?

**If you had to prioritize your concerns, what would you list first? Second?**

**Do you have any questions for us? Is there anything else you would like us to know?**