

SUMMARY

We hope that this manual will be a useful tool for you. Providing you with relevant information to help you advocate for the legal rights and options of your patients from a position of knowledge and strength, is our goal at the Cancer Legal Resource Center. If you or your patients have questions about cancer-related legal issues, please contact our national, toll-free Telephone Assistance Line at (866) THE-CLRC (866-843-2572) or visit our website at www.CancerLegalResourceCenter.org.

APPENDICES

INTRODUCTION:

Below are various sample letters, forms, and resources that have been referenced throughout this manual. These documents are designed to provide general information on the topics presented. They are provided with the understanding that the author is not engaged in rendering any legal or professional services by its publication or distribution. Although these materials were reviewed by a professional, they should not be used as a substitute for professional services. We recommend that individuals with questions or concerns about their legal options act immediately, as there may be specific legal time limitations that could affect the validity of any case and any possible legal options they may have. If you or your patients have additional questions, please contact the Cancer Legal Resource Center at (866) THE-CLRC or at www.CancerLegalResourceCenter.org.

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Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming (available at: www.disabilityrightslegalcenter.org/about/CLRCEducationalMaterialsandSeminars.cfm)

APPENDIX E1

Below is a Sample Reasonable Accommodation Request Letter to an Employer:

Date

Employer's Name
Employer's Address

Re: Request for Reasonable Accommodation

Dear (e.g. Supervisor, Manager, or Human Resources Personnel):

Content to consider in the body of the letter:

-Identify yourself as a person with cancer.

-State that you are requesting a reasonable accommodation under the Americans with Disabilities Act (ADA), § 501, 503, or 504 of the Rehabilitation Act.

-Identify your specific job tasks, which are causing you difficulty.

-Identify your accommodation idea.

-Request your employer's accommodations ideas.

*-Refer to attached medical documentation if appropriate. ***

-Ask your employer to respond to your request within a reasonable amount of time.

Sincerely,

Your signature
Your printed name
Your address
Your phone number or email address

Cc: to appropriate individuals

******You may wish to attach any medical information to your letter to help establish that you are a person with a disability and to document your need for an accommodation.

APPENDIX T1

Below is a Sample Conversation Asking a Health Care Provider for a Disability Determination Letter:

Dr. Smith: Good morning, Jane. How are you feeling?

Jane: Good morning, Doctor. Not too well, unfortunately. The chemotherapy and radiation therapy have really been taking a toll on me, and they're beginning to affect my work life. I plan on applying for Social Security disability benefits soon. In fact, I was hoping that you could help me by writing a disability determination letter. I think sending this type of letter to SSA would strengthen my application.

Dr. Smith: I'm more than happy to help. Would you mind giving me more information on how your work life has been affected?

Jane: I try to go to work three or four times a week, but the therapies have been making me so tired and weak that I'm having a hard time going in that often. Both sitting and walking are difficult, and I can't stand for over 20 minutes at a time. I'm also having trouble concentrating and struggle to lift things. I need to take a lot of breaks to get through the day.

Dr. Smith: And how about your depression? Have you been seeing the psychologist I referred you to?

Jane: Yes, she's been helpful, and I'm starting to feel better, but it's still a challenge.

Dr. Smith: That's good to hear. Is there anything else that you'd like me to include in the letter?

Jane: Details about my appointments with you and the pathologist would be helpful, and if you could attach my medical records and lab results, that'd be great as well.

Dr. Smith: Okay, I'll start working on the letter and send it to you as soon as I can.

Jane: Thank you. I really appreciate all of your help.

APPENDIX T2

Below is a Sample Disability Determination Letter from a Health Care Provider:

March 8, 2010

Brian Smith, MD
Oncologist, State University Cancer Center
1234 University Road
Big City, State 09876

Re: Miss Jane Jones

To Whom It May Concern:

My name is Dr. Brian Smith and I am an oncologist at the State University Cancer Center. I have been treating Miss Jane Jones for over a year and know her well.

According to my records (see attachment), I first met Miss Jones on January 15, 2009. Miss Jones was originally diagnosed with breast cancer, which has since metastasized to her lungs over the last six months. On February 3, 2009, I started Miss Jones on chemotherapy (one time per week for 12 weeks), as well as radiation treatment (one time per week for 6 weeks). Based on my chart notes, the treatment temporarily stopped the growth of cancer found in Miss Jones' left breast. However, upon further assessment, including x-rays on September 15, 2009, I noticed metastatic tumors in Miss Jones' lungs. On September 29, 2009, I performed a biopsy. Approximately one week later, Dr. Renee Reed, a pathologist at State University Cancer Center, determined that Miss Jones' cancer had spread (see lab results attached). Beginning October 28, 2009, my office began administering an aggressive combination of chemotherapy and radiation therapy.

As of February 25, 2009, my last office visit with Miss Jones, the patient has several limitations in the following areas: sitting, walking, focusing, concentrating, and lifting. In assessing Miss Jones' current condition, she cannot stand for more than 20 minutes at a time. Miss Jones needs considerable rest periods throughout the day and is often too sick from her cancer treatment to attend work 3-4 days/week. Additionally, as a result of Miss Jones' secondary cancer diagnosis, she has developed severe depression, to which she has already been referred to a psychologist to help treat this condition.

It is my professional opinion that Miss Jane Jones has a disability qualifying her for Social Security disability benefits.

If you have further questions, please contact me.

Best,

Brian Smith, MD.

Dr. Brian Smith

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
 No Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? No Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
 No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such as medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? No Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? No Yes.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? No Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ No ___ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ___ times per ___ week(s) ___ month(s)

Duration: ___ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___ No ___ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
Expires: 1/31/2012

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: () Fax: ()

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes.

Was medication, other than over-the-counter medication, prescribed? No Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ No ___ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ___ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___ No ___ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ___ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

APPENDIX D13

Below is a Sample Letter to Employer Asking for Time Off as a Caregiver:

September 14, 2011

Mr. Joe Human Resources
ABC Corporation
987 Business Boulevard
Anytown, CA 99999

Re: Request for Paid Family Leave

Dear Mr. Human Resources:

On September 13, 2011, my mother, Mary Smith, fractured her femur. According to her podiatrist, she is expected to require a care provider until October 31, 2011. I am the only family member who is ready, willing, and able to care for her at this time. Please consider this my official request for Paid Family Leave, to begin on September 20, 2011.

At this time I am unsure when my need for leave as a caregiver will end, but I would like to have an ongoing conversation about my need for leave. Please let me know if there are additional steps I need to take to obtain this leave, including whether or not I will need to complete any additional paperwork.

I would like to set up a time to discuss this request. I can be reached at 123-456-7890 or Jane.Jones@work.com.

Sincerely,

Jane Jones

Jane D. Jones

APPENDIX HI1

Below is a sample letter appealing an insurance company's decision to deny treatment or to refuse to cover the cost of treatment:

Date
Name of Health Care Representative
Health Plan Name
Address
City, State, Zip Code
Re: <u>Patient's Name, Type of Coverage, Group/Policy Number</u>
Dear _____ (Health Care Representative):
On _____ (date of diagnosis), _____ (Patient's Name), a beneficiary of your health insurance policy _____ (Group Number/Policy Number), was diagnosed with _____ (diagnosis). According to _____'s (Patient's name) physician, Dr. _____ (Physician's name), _____ (Patient's name) requires _____ (treatment that the insurance company is denying coverage for) as part of the treatment for _____ (diagnosis).
According to a letter _____ (Insurance Company's name) sent to _____ (Patient's name) on _____ (date of denial letter), _____ (treatment requesting) is not covered under _____ (Patient's name) insurance plan because _____ (explanation written in denial letter).
This letter serves as an appeal to _____ (Insurance Company's name) to _____ (what you are requesting Insurance company to do – e.g., pay for treatment). Dr. _____ (Physician's name) has also submitted an appeal on behalf of _____ (Patient's name), including details of his/her medical condition, copies of his/her medical records, and a thorough explanation as to why _____ (treatment requesting) is necessary. Based on the literature _____ (Insurance Company's name) sent to _____ (Patient's name) upon enrolling in this plan, _____ (Insurance Company's name) has _____ (number of days listed in Insurance Company's handbook) days to respond to this appeal.
Please reconsider your previous decision to _____ (what the Insurance company is refusing to do), as this medical procedure is necessary in _____ (Patient's name) treatment of _____ (diagnosis).
Sincerely,
Name
Address
Cc: _____ (anyone else you are sending this letter to)
Enclosures

Below is a sample of a completed letter appealing an insurance company's decision:

January 1, 2008

Mr. Joe Health Care Representative
ABC Health Care Insurance Company
100 Main Street
Big City, CA 90000

Re: Jane Smith, PPO, Group 123 / Policy Number ABC456

Dear Mr. Health Care Representative:

On April 1, 2007, Jane Smith, a beneficiary of your health insurance policy number ABC456 was diagnosed with breast cancer. According to Jane Smith's physician, Dr. Robert Feel Good, Jane requires a mastectomy as part of the treatment for her cancer diagnosis.

According to a letter ABC Health care Insurance Company sent to Jane Smith on December 1, 2007, a bilateral mastectomy is not covered under Jane Smith's insurance plan because her diagnosis is considered a pre-existing medical condition.

This letter serves as an appeal to ABC Health care Insurance Company to pay for Jane Smith's mastectomy, which was performed on October 1, 2007. Dr. Feel Good has also submitted an appeal on behalf of Jane Smith, including details of her medical condition, copies of her medical records, and a thorough explanation as to why the mastectomy is necessary and why her diagnosis should not be considered a pre-existing medical condition. Based on the literature ABC Health care Insurance Company sent to Jane Smith upon enrolling in this plan, ABC Health care Insurance Company has 30 days to respond to this appeal.

Please reconsider your previous decision to deny coverage for the mastectomy, as this medical procedure is necessary in Jane Smith's treatment of breast cancer.

Sincerely,

Fred Smith
500 S. Longroad Way
Small Town, CA 10000

Cc: Dr. Robert Feel Good

Enclosures

APPENDIX G1

Disability Rights Legal Center

CLRC

Cancer Legal Resource Center

CLRC National Office

800 S. Figueroa Street, Suite 1120

Los Angeles, CA 90017

Toll Free: 866.THE.CLRC (866.843.2572)

TDD: 213.736.8310 Fax: 213.736.1428

Email: CLRC@LLS.edu

Web: www.CancerLegalResourceCenter.org

The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

Definition of Genetic Information in State Laws

50 State Survey

	Explicitly Includes Family Medical History	Explicitly Excludes routine tests	Associated with a disease	Explicitly Includes Carrier Status	Applies to?
Alabama (27-53-1)	No	No	Yes	No	Health
Alaska (AS § 18.13.100) ¹	No	Routine	Maybe	No	Health
Arizona (ARS § 20-1379)	Yes	No	No	Yes	Health
Arizona (ARS § 20-448)	No	No	Yes	Yes	Life and Disability
Arkansas (A.C.A. § 11-5-402)	No	Routine	Yes		Emp. And Health
California	Yes	No	No	No	Emp. And Health
Colorado (C.R.S.A. § 10-3-1104.6)	Yes	No	No	No	Health
Colorado (C.R.S.A. § 10-3-1104.7)	No	No	Yes	No	Group Disability Insurance or Long-term Care Insurers
Connecticut (C.G.S.A. § 38a-816)	No	No	No	No	Health
District of Columbia (ST § 2-1401.02)	No	Routine	Yes	No	Emp. And Health
Deleware (18 Del.C. § 2317)	No	No	Yes	Yes	Emp. And Health
Florida (West's F.S.A. § 627.4301)	No	Routine	Yes	Yes	Health

	Explicitly Includes Family Medical History	Explicitly Excludes routine tests	Associated with a disease	Explicitly Includes Carrier Status	Applies to?
Georgia (Ga. Code Ann., § 33-54-2)	No	Routine	Yes	No	Health
Hawaii (HRS § 378-1)	Yes	No	No	No	Employ
Idaho (I.C. § 39-8302)	GT only	Routine	No	Yes	Emp. And Health
Illinois (410 ILCS 513/10)	Yes	Routine	Yes	No	Emp. And Health
Indiana (IC 27-8-26-2)	No	No	Yes	Yes	Health
Iowa (I.C.A. § 729.6)	Yes	Routine	No	No	Emp. And Health
Kansas (K.S.A. 40-2259; K.S.A. 44-1002)	No	No	Yes	Yes	Health
Kentucky (None)	-	-	-	-	-
Louisiana (LRS 22:1023)	Yes	No	No	No	Health
Louisiana (LRS 23:302)	Yes	Routine	No	No	Employ
Maine (24-A M.R.S.A. § 2159-C and M.R.S.A. § 19301)	No	No	Yes	No	Emp. And Health
Maryland (MD Code, Insurance, § 27-909)	No	Routine	Yes	No	Emp. And Health
Massachusetts (M.G.L.A. 151B § 1)	No	No	No	No	Employ
Massachusetts (M.G.L.A. 175 § 120E)	No	Yes	Yes	No	Insurance
Michigan (M.C.L.A. 37.1201)	Yes	Yes	Yes	No	Emp. And Health
Minnesota (MS §181.974)	No	No	Yes	No	Employ
Minnesota (MS §72A.139)	No	No	Yes	Yes	Insurance
Mississippi (none)	-	-	-	-	-
Missouri (MRS §§375.1300)	No (explicitly)	Yes	Yes	No	Emp. And Health
Montana (MCA §33-18-901)	No (explicitly)	Yes	Yes	Yes	Insurance

	Explicitly Includes Family Medical History	Explicitly Excludes routine tests	Associated with a disease	Explicitly Includes Carrier Status	Applies to?
Nebraska (Neb.Rev.St. § 44-7,100. Neb.Rev.St. § 48-236)	No	Yes	Yes	No	Emp. And Health
Nevada (N.R.S. 613.345, N.R.S. 689A.417)	No	Some	Yes	No	Emp. And Health
New Hampshire (N.H. Rev. Stat. § 141-H:1)	No	Some	No	No	Emp. And Health
New Jersey (N.J.S.A. 10:5-5, N.J.S.A. 17:48-6.18)	No	No	Yes	No	Emp. And Insurance
New Mexico (N. M. S. A. 1978, § 24-21-2)	No	Yes	Yes	Yes	Emp. And Insurance
New York (McKinney's Executive Law § 292)	No	No	Yes	No	Employ
New York (McKinney's Civil Rights Law § 79-l)	No	Yes	Yes	Yes	Insurance
North Carolina (N.C.G.S.A. § 58-3-215)	No	Yes	No	No	Insurance
North Carolina (N.C.G.S.A. § 95-28.1A)	No	No	Yes	No	Employ
North Dakota (none)	-	-	-	-	-
Ohio (R.C. § 1751.64)	No	No	Yes	Yes	Insurance
Oklahoma (36 Okl.St. Ann. § 3614.2)	No (explicitly)	Yes	Yes	No	Employ
Oklahoma (36 Okl.St. Ann. § 3614.1)	Yes	Yes	No	No	Insurance
Oregon (O.R.S. § 192.531)	No (explicitly)	No	No	No	Emp. And Insurance
Pennsylvania	-	-	-	-	-

	Explicitly Includes Family Medical History	Explicitly Excludes routine tests	Associated with a disease	Explicitly Includes Carrier Status	Applies to?
Rhode Island (Gen.Laws 1956, § 27-18-52 and Gen.Laws 1956, § 28-6.7-2.1)	No	Yes	Yes	Yes	Emp. And Insurance
South Carolina (Code 1976 § 38-93-10)	Yes	Yes	No	No	Insurance
South Dakota (SDCL § 58-1-24, SDCL § 60-2-21)	Yes	Yes	No	Yes	Emp. And Insurance
Tennessee (T. C. A. § 56-7-2702)	No (explicitly)	Yes	Yes	Yes	Insurance
Texas (V.T.C.A., Insurance Code § 546.001)	No	Yes	Yes	Yes	Insurance
Texas (V.T.C.A., Labor Code § 21.401)	Yes	Yes	Yes	Yes	Employ
Utah (U.C.A. 1953 § 26-45-102)	No	Yes	No	No	Emp. And Insurance
Vermont (18 V.S.A. § 9331)	No	No	Yes	No	Emp. And Insurance
Virginia (VA Code Ann. § 38.2-508.4)	No	No	Yes	No	Emp. And Insurance
Washington (West's RCWA 49.44.180)	Yes	Yes	No	No	Employ
West Virginia	-	-	-	-	-
Wisconsin (W.S.A. 111.32)	No	No	Yes	Yes	Employ
Wisconsin (W.S.A. 631.89)	No	No	Yes	No	Insurance
Wyoming	-	-	-	-	-

¹ - however for health insurance Alaska law models GINA and thus includes family history.

APPENDIX G2

Disability Rights Legal Center

CLRC

Cancer Legal Resource Center

CLRC National Office

800 S. Figueroa Street, Suite 1120

Los Angeles, CA 90017

Toll Free: 866.THE.CLRC (866.843.2572)

TDD: 213.736.8310 Fax: 213.736.1428

Email: CLRC@LLS.edu

Web: www.CancerLegalResourceCenter.org

The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

Regulation of Genetic Information in Life, Long Term Care, and Disability Insurance

50 State Survey

	No Protections	Informed Consent Needed	Disability Insurance Regulation	Life Insurance Regulation	Long-term Care Regulation	Needs Actuarial Justification
Alabama	X					
Alaska (§ 18.13.100)		W				
Arizona (§ 12-2801 et.seq), ARS §20-448, 20-448.02		W	X	X	X	X
Arkansas	X					
California			X	X	X	
Colorado (C.R.S.A. § 10-3-1104.6-1104.7)		W (applies to life, individual disability, and group and long-term care)	X		X	
Connecticut	X					
District of Columbia	X					
Deleware (16 Del.C. § 1221)		W				
Florida	X (except for sickle cell)					
Georgia (Ga. Code Ann., § 33-54-3)	X					
Hawaii	X					
Idaho (I.C. § 41-1313)			X			
Illinois	X					

	No Protections	Informed Consent Needed	Disability Insurance Regulation	Life Insurance Regulation	Long-term Care Regulation	Needs Actuarial Justification
Indiana (IC 16-39-5-2)		W (except for life ins.)				
Iowa (I.C.A. § 729.6)		W				
Kansas (K.S.A. 40-2259)			X		X	
Kentucky (KRS § 304.12-085)			X			
Louisiana	X (except for sickle cell)					
Maine (24-A M.R.S.A. § 2159-C)		X	X	X	X	X
Maryland (MD Code, Insurance, § 18-120, MD Code, Insurance, § 27-208)				X	X	X
Massachusetts (M.G.L.A. 175 § 120E, M.G.L.A. 175 § 108I)			X	X	X	X
Michigan	X					
Minnesota (MS §72A.139)		W		X		
Mississippi	X					
Missouri	X					
Montana (MCA 33-18-206)			X	X		X
Nebraska	X					
Nevada	X					
New Hampshire (N.H. Rev. Stat. § 141-H:5)	X (except can't use in other insurances)					
New Jersey (N.J.S.A. 17B:30-12)		X	X	X		X
New Mexico (N. M. S. A. 1978, § 24-21-3)		(Notification only)	X	X	X	X
New York (McKinney's Insurance Law § 2615)		W	X	X	X	
North Carolina (N.C.G.S.A. § 58-58-25)	X (except for sickle cell)					
North Dakota	X					
Ohio	X					
Oklahoma	X					
Oregon (O.R.S. § 746.135)			X	X	X	

	No Protections	Informed Consent Needed	Disability Insurance Regulation	Life Insurance Regulation	Long-term Care Regulation	Needs Actuarial Justification
Pennsylvania	X					
Rhode Island (Gen.Laws 1956, § 27-18-52)	X					
South Carolina	X					
South Dakota	X					
Tennessee (T. C. A. § 56-7-2705)	X					
Texas	X					
Utah	X					
Vermont (18 V.S.A. § 9334)		X	X	X	X	
Virginia	X					
Washington	X					
West Virginia	X					
Wisconsin (W.S.A. 631.89)				X		X
Wyoming (W.S.1977 § 26-5-103)	X					

APPENDIX M1

You can stop a debt collector from contacting you by writing a letter to the collector telling them to stop. Once the collector receives your letter, they may not contact you again except to say there will be no further contact or to notify you that the debt collector or the creditor intends to take some specific action. Although the letter will stop any communication regarding the debt, it will NOT cancel the debt. You could still be sued by the debt collector or your original creditor for the total amount of the debt.

Below is a sample "Notice to Cease and Desist Communication" letter:

Date

(Debt Collector Name)

(Debt Collector Address)

RE: Creditor: (Name of Company you owe money)
Acct No.:

NOTICE TO CEASE AND DESIST COMMUNICATION

To Whom It May Concern:

This is formal notice to cease and desist any further written or oral communication with me regarding the above-referenced account. I am unable to pay the amount demanded on the account.

I receive limited income for my basic necessities and I do not own real property. My financial situation is not likely to improve. This information is provided solely to enable you to properly assess my situation.

Be advised that under both state and federal fair debt collection laws, if a consumer notifies a debt collector in writing that the consumer wishes the debt collector to cease further communication with the consumer, the debt collector SHALL NOT communicate further with the consumer with respect to such debt.

Thank you in advance for your cooperation in this matter.

Sincerely,
DEBTOR
(Your Name)

APPENDIX EP1

Disability Rights Legal Center

CLRC

Cancer Legal Resource Center

CLRC National Office

800 S. Figueroa Street, Suite 1120

Los Angeles, CA 90017

Toll Free: 866.THE.CLRC (866.843.2572)

TDD: 213.736.8310 Fax: 213.736.1428

Email: CLRC@LLS.edu

Web: www.CancerLegalResourceCenter.org

The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

Personal Record File

This Personal Record File will be helpful to your loved ones by gathering in one place, copies of important records and documents they will need. The items on the list can be kept in an envelope or other document holder and marked to show the contents and kept in a place known to your loved ones. Originals should be kept in a fireproof place, such as a safe deposit box, if appropriate.

1. Will, with name, address, and phone number of attorney.
2. Birth certificates for yourself, spouse, and children.
3. Marriage license and/or proof of divorce, if applicable.
4. Drivers' license and social security card.
5. Life, medical, dental, property, and auto insurance policies, with name, address, and phone number of insurance agent(s).
6. Proof of automobile ownership and registration, license plate number, and VIN number.
7. Real estate deed, title policies, mortgages, record of payments, tax receipts, receipts for improvements, etc.
8. Names of banks, savings, retirement and securities accounts, loans, and their account numbers.
9. Computer, voicemail, and internet user names and passwords for financial accounts, etc.
10. List of other assets and locations (including loans, deeds of trust and accounts receivable).
11. Safe-deposit box key, name and address of bank, and box number.
12. Name of credit card creditors and account numbers.
13. Veteran's discharge paper (DD-214).
14. Income tax returns for the last three years, and name and address of persons preparing the returns.
15. Name and address of broker or stock certificates and bonds you own (and purchase slips or other records of cost/date of purchase).
16. Receipts/appraisals for items of substantial value such as jewelry, furs, furniture, art, etc.
17. Name, address, and telephone number of your employer and/or supervisor.
18. Documentation of retirement benefits, pension plan, and profit sharing.
19. Business records.
20. List of close relatives, addresses, and telephone numbers.
21. Funeral or memorial instructions.
22. General instructions to surviving spouse or children, including a list of advisers.
23. **Any other information you would like to include.**

APPENDIX EP2

Disability Rights Legal Center

CLRC

Cancer Legal Resource Center

CLRC National Office

800 S. Figueroa Street, Suite 1120

Los Angeles, CA 90017

Toll Free: 866.THE.CLRC (866.843.2572)

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The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

“Taking Care of Business”

The Cancer Legal Resource Center has designed this information sheet so that you can collect and keep personal and financial information in one place. Keep it in a safe place known to your spouse and other loved ones. Update it as needed. And, feel free to modify and/or change it to meet your particular and special needs.

1. GENERAL INFORMATION

Name: _____

Home Address: _____

Phone: (Home) _____ (Work) _____

Employer/Work Address: _____

Work Telephone: _____

Date of Marriage: _____

Date of Separation/Divorce (if applicable): _____

Children of this Marriage:

Name

Date of Birth

Other Children:

Name

Date of Birth

2. INVENTORY OF ASSETS

(Assets include things like homes, real estate, investments, business interests, bank accounts, pensions, retirement benefits, life insurance policies, lines of credits, and personal property such as vehicles, jewelry and furniture.)

a. Real Property

i. Type of Property and Address:

Lender (s) [Name and Address]: _____

Account Number: _____ Date of Purchase: _____

Amount of Debt Owed: _____

Your estimate of the current selling price: _____

Your estimate of the equity in the property: _____

What is your plan for the use or sale of the property: _____

Other issues regarding the property: _____

ii. Type of Property and Address:

Lender (s) [Name and Address]: _____

Account Number: _____ Date of Purchase: _____

Amount of Debt Owed: _____

Your estimate of the current selling price: _____

Your estimate of the equity in the property: _____

What is your plan for the use or sale of the property: _____

Other issues regarding the property: _____

b. Financial Assets

i. Life Insurance

Name/Address of Insurance Co.: _____

Phone: _____ Policy Number: _____

Face Value: _____ Cash Surrender Amount: _____

Insured Party: _____

Beneficiaries: _____

Discussion Issues Regarding Life Insurance: _____

Name/Address of Insurance Co.: _____

Phone: _____ Policy Number: _____

Face Value: _____ Cash Surrender Amount: _____

Insured Party: _____

Beneficiaries: _____

Discussion Issues Regarding Life Insurance: _____

ii. Pensions, Retirement Benefits, Profit Sharing

Type of Benefit: _____

Name of Administrator: _____

Address: _____

Phone: _____ Plan Number: _____

Current Amount: _____ In the Name Of: _____

Beneficiaries: _____

Type of Benefit: _____

Name of Administrator: _____

Address: _____

Phone: _____ Plan Number: _____

Current Amount: _____ In the Name Of: _____

Beneficiaries: _____

iii. Bank Accounts, Investment Accounts, Lines of Credit, Stock Certificates, Etc.

Type of Account/Name of Institution/Account Number: _____

Balance: _____ Maturity Date: _____

Number of Shares (if applicable): _____

Special Circumstances/Discussion Issues: _____

Type of Account/Name of Institution/Account Number: _____

Balance: _____ Maturity Date: _____

Number of Shares (if applicable): _____

Special Circumstances/Discussion Issues: _____

Type of Account/Name of Institution/Account Number: _____

Balance: _____ Maturity Date: _____

Number of Shares (if applicable): _____

Special Circumstances/Discussion Issues: _____

iv. Business Interests

Name and Nature of Business: _____

Ownership/Partnership/Name: _____

Date Acquired: _____ Salary: _____

Buy/Sell Agreement: _____ Insurance Policies: _____

Special Circumstances/Discussion Issues: _____

Name and Nature of Business: _____

Ownership/Partnership/Name: _____

Date Acquired: _____ Salary: _____

Buy/Sell Agreement: _____ Insurance Policies: _____

Special Circumstances/Discussion Issues: _____

c. Personal Property

(Personal property includes vehicles, jewelry, furniture, appliances, art work, etc.)

Item:

Location of Item:

1.

1.

2.

2.

3.

3.

4.

4.

5.

5.

6.

6.

3. INVENTORY OF DEBTS, CREDIT CARDS, ETC.

Type of Account	Number	Name of Creditor
-----------------	--------	------------------

Monthly Payment	Amount Owed	
-----------------	-------------	--

Type of Account	Number	Name of Creditor
-----------------	--------	------------------

Monthly Payment	Amount Owed	
-----------------	-------------	--

Type of Account	Number	Name of Creditor
-----------------	--------	------------------

Monthly Payment	Amount Owed	
-----------------	-------------	--

Type of Account	Number	Name of Creditor
-----------------	--------	------------------

Monthly Payment	Amount Owed	
-----------------	-------------	--

Type of Account	Number	Name of Creditor
-----------------	--------	------------------

Monthly Payment	Amount Owed	
-----------------	-------------	--

Type of Account	Number	Name of Creditor
-----------------	--------	------------------

Monthly Payment	Amount Owed	
-----------------	-------------	--

DISCLAIMER: This publication is designed to provide general information on the topics presented. It is provided with the understanding that the author is not engaged in rendering any legal or professional services by its publication or distribution. Although these materials were reviewed by a professional, they should not be used as a substitute for professional services. The CLRC has no relationship or affiliation with the referral agencies, organizations or attorneys to whom we refer individuals. Resources and referrals are provided solely for information and convenience. Therefore, the CLRC disclaims any and all liability for any action taken by any entity appearing on the CLRC's resource and referral lists.

APPENDIX EP3

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Estate Planning Checklist

This Estate Planning Checklist can help you think about the process of planning your estate, including thinking about your wishes and who will ensure they are met. See the Estate Planning chapter of this manual for more information about this topic.

- Have you begun to think about your wishes for your medical, personal, emotional, and financial needs in the event you are unable to care for yourself?
- Have you considered discussing your wishes with someone you trust, such as your family or friends, to make sure that your wishes are carried out?
- Have you considered who you would like to receive your assets?
- Have you considered when you would like your assets to be transferred (e.g., during your lifetime, at death, or sometime later)?
- Do you want a will?
- Do you want a living trust or another type of trust?
- If you have estate planning documents are they up to date? For instance, do they reflect your current personal or real property or assets? Do they accurately reflect your current wishes?
- Do you have a life and/or an accidental death insurance policy? Is your beneficiary up to date?
- Have you considered if you would want to appoint someone to act as your Power of Attorney for Financial Affairs if you are unable to make financial decisions for yourself?
- Have you considered preparing an Advance Health Care Directive (including living wills, powers of attorney for health care, and organ donation)?
- Have you considered if you would want to appoint someone to act as your agent to make your medical decisions if you could not make them for yourself?
- Have you let someone you trust, such as a family member or friend, know where your important documents are kept or have you given them the phone number of your estate planning attorney?
- Have you considered having a plan in place to deal with practical issues in the event you are unable to handle these daily tasks yourself? For instance:
 - Who would pay my rent and other bills?
 - Who would feed my pets?
 - Who would pick up my children from school?

APPENDIX LA1

Below is a sample letter to your elected official:

Date
The Honorable (insert full name) (Insert body of government) (Insert address)
Dear _____(insert title) (insert last name),
I am a constituent and live at _____(insert your address). I am writing to you to ask _____ (purpose of letter – i.e. if you have a specific bill number mention it here).
_____ (describe your personal story; state why you have been affected by this situation; why the bill is important to you; etc).
Your support would make a difference in the lives of your constituents like me. Please _____ (insert purpose of letter). I would appreciate if you would let me know of your action in this matter.
Sincerely,
Your full name Your full address (establishes that you are a constituent) Your phone number

Below is a sample of a completed letter to your elected official:

January 1, 2008
The Honorable Joe Lawmaker U.S. House of Representatives 202 Longworth House Office Building Washington, D.C. 20515
Dear Representative Lawmaker:
I am a constituent and live at 234 Creek Lane, in Lakeview, California. I am writing to ask you to vote in support of H.R. 405, which increases funding for cancer research through the National Cancer Institute.
I am a breast cancer survivor and many members of my family have been touched by cancer, as well. It is so important to us that we do everything that we can to support the search for a cure for cancer, so that no one else has to go through what we did.
Your support would make a difference in the lives of your constituents like me. Please support H.R. 405. I would appreciate it if you would let me know of your action in this matter.
Sincerely,
Jane Q. Public 234 Creek Lane Lakeview, CA 90000 (888) 555-1000

APPENDIX LA2

Below is a sample letter requesting a meeting with your elected official:

Date

VIA FACSIMILE: (enter fax number)

To: The Honorable (insert full name)
(Insert government body)
(Insert address)

Cc: Name of scheduler

Re: Meeting Request for (insert dates you are available to meet)

I am respectfully requesting a meeting with you on _____ (insert dates you are available to meet) between _____ (time you are available to meet). I am _____ (briefly introduce yourself or your organization).

_____ (discuss reasons for your meeting).

_____ (if you are bringing other advocates with you, let your representative know here).

I/We will contact your office to discuss this appointment. You can reach me at _____ (insert phone number) or _____ (email address) to arrange the appointment.

Thank you for your consideration of this request.

Sincerely,

Your Full Name
(Insert constituent or name of organization and position)
Your Full Address
Your Phone Number

Below is a sample of a completed meeting request letter:

January 1, 2008

VIA FACSIMILE: (202) 555-1000

To: The Honorable Joe Lawmaker
U.S. House of Representatives
202 Longworth House Office Building
Washington, D.C. 20515

Cc: Ryan Scheduler

Re: Meeting Request for April 25, 2008

I am respectfully requesting a meeting with you on April 25, 2008, or April 26, 2008, between 9:00 am – 5:00 pm. I am a constituent and live at 234 Creek Lane in Lakeview, California 90000.

I would like to discuss the recently introduced H.R. 405, which increases funding for cancer research through the National Cancer Institute.

I am a breast cancer survivor and many members of my family have been touched by cancer as well. It is so important that we do everything that we can to support the search for a cure for cancer, so that no one else has to go through what we did.

I will contact your office to discuss this appointment. You can also reach me at (888) 555-1000 or at jane.q.public@email.com to arrange this appointment.

Thank you for your consideration of this request.

Sincerely,

Jane Q. Public
234 Creek Lake
Lakeview, CA 90000
(888) 555-1000

APPENDIX LA3

Below is a sample conversation of what you can say when you call your elected official's office:

“Hi. My name is [name]. I am a constituent and I live [and/or work] in [town, city, county, state]. I am calling in regards to bill [bill number], [briefly describe the bill]. [Describe why the bill impacts you and your community]. I urge [name of legislator] to support bill [bill number]. Can you tell me how he/she is planning to vote on this bill?

If you have questions I can provide you with further information on this issue. Thank you for your time.”

Below is a completed sample conversation of what you can say when you call your elected official's office:

“My name is Jane Public. I am a constituent and I live in Lakeview, CA. I am calling in regards to H.R. 405, which increases funding for cancer research through the National Cancer Institute. This bill is critical to continue effective cancer research. Cancer kills nearly 500,000 people each year. I urge Representative Lawmaker to support H.R. 405. Can you tell me how he is planning to vote on this bill?

If you have questions I can provide you will further information on this issue. Thank you for your time.”

APPENDIX LA4

Sample of a completed press release:

Disability Rights Legal Center

CLRC

Cancer Legal Resource Center

For Immediate Release:

March 27, 2009

Contact:

Paula Pearlman: 213.736.8362, Paula.Pearlman@lls.edu

Joanna Morales: 213.736.8364, Joanna.Morales@lls.edu

CANCER LEGAL RESOURCE CENTER RECEIVES LANCE ARMSTRONG FOUNDATION 2009 COMMUNITY PROGRAM GRANT

LOS ANGELES, March 17, 2009 – The Cancer Legal Resource Center (CLRC), a joint project of the Disability Rights Legal Center (DRLC) and Loyola Law School, announced today that it is the recipient of a 2009 Lance Armstrong Foundation Community Program Grant. The community program of the Lance Armstrong Foundation (LAF) provides financial support and capacity-building to community-centered initiatives that address the physical, emotional and practical challenges of cancer survivorship.

A cancer diagnosis can carry with it a variety of legal issues, including insurance coverage, employment discrimination, access to health care, government benefits, and estate planning. These legal issues can cause people unnecessary worry, confusion, and stress, and can be overwhelming. When these legal issues are not addressed, people may find that although they have survived the disease, they have lost their homes, jobs, insurance, or families.

“We are extremely delighted to receive the LAF grant and the opportunity it offers to focus on educating health care professionals about cancer-related legal issues that their patients may face,” said Joanna L. Morales, Director of the Cancer Legal Resource Center. “The LAF is a generous supporter of community organizations that help people with cancer. We appreciate the foundation’s recognition of our efforts to provide legal information and resources to thousands of people every year.”

The CLRC provides free and confidential information and resources on cancer-related legal issues nationwide, to cancer survivors, caregivers, employers, health care professionals, and others coping with cancer. The CLRC’s caring, respectful assistance helps callers resolve their legal issues, focus on their recovery, and get back to their lives. Throughout its 12-year history, the CLRC has served over 90,000 people through the Telephone Assistance Line, conferences, seminars, workshops, outreach programs, and other cancer community activities.

About the Disability Rights Legal Center

The mission of the DRLC is to champion the rights of people with disabilities through education, advocacy, and litigation. The DRLC provides legal and related services through its five programs: [Cancer Legal Resource Center](#), Civil Rights Litigation Program, Community Outreach Program, Education Advocacy Program, and Community Advocacy. For more information, visit www.disabilityrightslegalcenter.org.