Mid-Nassau

Lend a Helping Hand

Serving Carle Place, Glen Cove, Hempstead, East Meadow, Mineola, Westbury and Uniondale

Dear Applicant,

Mid-Nassau Lend a Helping Hand is a support program. Our purpose is to support individuals of Glen Cove, Carle Place, Freeport, Hempstead, Westbury, East Meadow, Garden City, Uniondale and Mineola- through the demands and stresses of everyday living , while undergoing treatment for breast cancer. To qualify, you need to:

- Have a Doctor's confirmation showing current treatment for Breast Cancer.
- Be a resident of Hempstead, Westbury ,East Meadow, Garden City, Uniondale, Freeport, Carle Place, Glen Cove or Mineola
- Sign the confidentiality release form

The enclosed application lists the services we offer. Please contact us about any special need you may have. Once your application has been received, a volunteer will be in touch with you to make arrangements. Please fax your application to us **at 1-(888) 420-1030**. If you prefer to mail your application, please contact us **first** and then mail to :
53 East Merrick Road #101
Freeport, NY 11520

It is our wish that we can be a supportive and caring resource for you. Please feel free to contact us anytime at 1(888) 420-1030.

Sincerely,

The Volunteers at "Mid-Nassau Lend a Helping Hand"

53 East Merrick Road # 101 Freeport, NY 11520
Phone/Fax: 1(888) 420-1030
www.midnassaulahh.com

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Mid-Nassau Lend a Helping Hand Application

NAME: _____
Last First MI

ADDRESS: _____
House # Street

_____
Town State Zip Code

TELEPHONE: _____
Home Cell Business

NUMBER OF YEARS AT THIS ADDRESS: _____

AGE: _____ DATE OF BIRTH _____

MARITAL STATUS: Married _____ Single _____

NAME OF SPOUSE: _____

CHILDREN: Yes _____ No_____

NUMBER OF CHILDREN: _____ AGES:_____

TREATING PHYSICIAN: _____
Name

_____
Address

_____
Telephone Number

DIAGNOSIS:_____

TREATMENT_____

SPECIAL MEDICAL NEEDS OR OTHER CONSIDERATIONS:

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53 East Merrick Road # 101 Freeport, NY 11520
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Please list in order of preference the services that you are interested in*:

____ Reimbursement for travel to/from medical appointments

____ Emergency financial assistance

____ House cleaning

____ Reimbursement for child care

____ Assistance with obtaining wigs/prosthesis

____ Massage therapy

____ Support group

____ Individual counseling

____ Prepared meals

____ Other, please explain _____

***Subject to maximum amount and availability per qualified applicant.**

All services provided are subject to availability and prior approval by the Mid-Nassau Lend a Helping Hand Program and subject to maximum amount per qualified applicant.

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of Mid-Nassau Lend a Helping Hand regarding the requested program.

I understand and recognize that the granting of any service and the participation of any person in the program is contingent upon approval by the Mid-Nassau Lend a Helping Hand program, as well as, compliance with all conditions , qualifications and restrictions designed by the Mid-Nassau Lend a Helping Hand Program.

I certify that the above information is true and correct.

_____

(Applicant's Signature) **(Date)**

ALL INFORMATION WILL BE KEPT IN THE UTMOST CONFIDENCE.

DATE: _____

This letter is to certify that _____

Residing at _____

Is my patient, and is currently receiving treatment for Breast Cancer.

_____

Office Authorization and Stamp