



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 Carle Place, 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 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.

It is our wish that we can be a supportive and caring resource for you. Please feel free to contact us any-time at (631) 789-2068.

Sincerely,

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

P.O. Box 292, Amityville, NY 11701  
Phone: 631.789.2068 • Fax: 631.789.2069  
midnassaulahh@aol.com • www.midnassaulahh.com



# Lend a Helping Hand

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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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**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)**



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**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