Long Island Community Hospital

Lend a Helping Hand Application

In order for your request to receive full consideration, please complete all section, sign on the designated lines in the presence of a witness and return to the address indicated at the bottom of this form. *This information will be strictly used to determine eligibility for the Lend a Helping Hand Program.*

Patient Information Date:_________________

Participant's Name: ____ Age: _____ /D.O.B.______

Address: ____County:_____US Citizen___

Home Phone: ____________________________ Work Phone: ____________________________

Cell Phone: ______________________________ Email: _________________________________

May we contact you via Email? Yes ________ No ________

Have you ever been helped by another Coalition? _______________________________________

Single: ________ Married: ________ Significant Other/Partner: ______________

Number of Household Members at Home: ________ Ages: _________________________

Level of Education ________________________ Occupation______________________________

Employment Status: _______ Patient Income: __________________________

Household Income: $_______________________ Change since diagnosis? $____________________

Insurance Carrier: _________________________ Medicaid___________Medicare_____________

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Long Island Community Hospital Breast Cancer Survivorship Coalition

Medical Information

Referring Doctor: ___________________________ Office Phone: ______________________

Oncologist: ________________________________ Office Phone: ______________________

Radiologist: ________________________________ Office Phone: ______________________

Surgeon: __________________________________ Office Phone: ______________________

Chemo/Radiation Facility: ____

Address: ____

Phone: ______________________________

Nurse/Social Worker/Contact Person: ____

Medical Diagnosis: ______________________________________ Date of Diagnosis: ________

Current Treatment: _________________________ Date Treatment Began/Will Begin: ________

Anticipated Length of Treatment: __________________________

AUTHORIZATION FOR RELEASE OF MY HEALTH INFORMATION NECESSARY TO DETERMINE MY ELIGABILITY TO PARTICIPATE IN THE LEND A HELPING HAND PROGRAM:
I understand that only patients in active treatment for breast cancer are eligible to participate in the *Lend a Helping Hand Program*.
I hereby authorize the individuals identified by me above to provide written and or oral information to representatives of the LI Community Hospital Breast Cancer Survivorship Coalition necessary to determine my eligibility to participate in the *Lend a Helping Hand Program*.
I understand that signing this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the LI Community Hospital Breast Cancer Survivorship Coalition in writing. I further understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I acknowledge that my enrollment in the *Lend a Helping Hand Program* will result in disclosure of my eligibility status.

____ ________________________________
Signature Date
Print Name___________________________________

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Liability Release

Participants understand that involvement in LI Community Hospital BCSC's LAHH Program may involve risk of injury or harm, and agree that this risk is fully assumed by the Participant. In addition, and in view of LI Community Hospital BCSC considering LAHH requests, and if it so determines, granting the request, the Participant hereby releases and agrees to hold LI Community Hospital BCSC harmless for, from and against any and all liability, damages and claims of any kind, known and unknown, which may be connected with, result from, or arise out of the consideration, preparation, fulfillment of participation in the LAHH. This includes, but is not limited to, any problems with transportation, food and lodging, medical condition, both physical and emotional, entertainment, photographs, publicity, accidental injury or death.

I understand and agree that representatives of the LI Community Hospital BCSC have made no promises or assurances regarding the requested project. I understand and recognize that the granting of any service and participation in LAHH is contingent upon approval by the LI Community Hospital BCSC as well as compliance with all conditions, qualifications and restrictions designated by the LI Community Hospital BCSC. ***I also understand that there is a limit to the number of services that I will receive, depending upon the type and cost of service being requested and offered.***

Participant acknowledges reading and understanding the above LIABILITY RELEASE prior to signing it. Participant agrees that no modification of this Release has been made orally or in writing and this release accurately and fully expresses the understanding of the participant.

____

Participant **Date**

____

Additional Signature (if participant unable to sign) **Date**

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Publicity Authorization

Participant understands and agrees that fulfillment of their request may result in publicity, whether or not LI Community Hospital BCSC actively takes steps to publicize LAHH.

Option 1: The Participant hereby irrevocably **authorizes LI Community Hospital BCSC (a) to publicize and use** their likeness, voice and features, with or without their name, for any publication, promotion, trade, business use, or any other purpose whatsoever; (b) to photograph, videotape, film and record each participant in any manner LI Community Hospital BCSC chooses; (c) to copyright, convey, or otherwise distribute, now or in the future, any such material involving the Participants for any purpose to anyone, including the general public, magazines, newspapers, television, radio stations or anyone else; (d) to publicize, now or in the future, the names of the Participants including information regarding them, their physical or emotional conditions.
Each of the Participants agrees that it is not necessary for LI Community Hospital BCSC or anyone else to contact them prior to releasing any information authorized by this document. Each of the Participants hereby release LI Community Hospital BCSC from all liability, damages or claims of any kind resulting from photographs, films, videotapes, electronic recording or other information regarding Participant and LAHH. **Initial here if Option 1 is selected: ________**

Option 2: Participant requests that their LAHH specifics **not be actively publicized** by LI Community Hospital BCSC to the news media and general public. However, each of the Participants understands that information regarding LAHH and the Participant will necessarily be discussed with and disclosed to those involved in the implementation of LAHH. Each of the Participants also understands that even if LI Community Hospital BSCS does not actively publicize LAHH, the general public and the news media may obtain information concerning the Participant and the Project from other sources. **Initial here if Option 2 is selected: ________**

Participant acknowledges reading and understanding the above PUBLICITY AUTHORIZATION prior to signing it. Participant agrees that no modification of this authorization has been made orally or in writing and this release accurately and fully expresses the understanding of the participant.

______________________________________	________________________
Participant	**Date**
______________________________________	________________________
Additional Signature (if participant unable to sign)	**Date**

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Please * the service that would best suit your needs and check √ any others that might apply to your needs:

______ Grocery Card

______ Transportation Service – To/From Breast Cancer related treatments/appts

______ Financial / Co-Pay Assistance

______ Massage therapy

______ Salon Services – Manicure, Pedicure, etc

______ Other (please explain) ____

Long Island Community Hospital

Lend a Helping Hand Release Information Form

I hereby give permission to the LI Community Hospital Breast Cancer Survivorship Coalition to release information regarding the diagnosis of:

_________________________________ / ________________________________ / _______

Patient's Name Patient's Signature Date

This information will be strictly used to determine eligibility for the Lend a Helping Hand program.

Long Island Community Hospital
Breast Cancer Survivorship Coalition
101 Hospital Road
Patchogue, NY 11772
Phone: 631-654-7577 Fax: 631-539-8862