Carin MacLean Foundation Inc. Application for Assistance

The Carin MacLean Foundation Inc. is an independent 501(c)(3) non-profit organization. Our mission is to foster a sense of community and connection for moms fighting cancer and to ease the financial and emotional hardships for those moms and their families.

GUIDELINES FOR FINANCIAL ASSISTANCE:

- Female Adult Patient who is a parent of minors – currently residing with them
- Patient is in active treatment; defined as 3 or more appointments a year with an MD, NP, or PA
- A New England resident and Permanent Resident of the United States
- In need of financial assistance due to expenses from diagnosis such as excessive medical bills, child care, housecleaning, and wage loss
- All applications must be submitted by Social Worker
- Applications are only accepted from July 1st through December 31st

Please send completed application to:

Carin MacLean Foundation Inc.

P.O. Box 81

Seekonk, MA 02771

or by email to:

contact@carinmacleanfoundation.org

If you have any questions, please contact us at (508) 343-0263 or by email at contact@carinmacleanfoundation.org

All information is strictly confidential.

For Office Use Only

Date Rec'd: _____

File No: _____

NOTE: All information will be kept strictly confidential

PATIENT INFORMATION (please print clearly)

Application Date: _____

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Phone Number: Home ( ) _____ Work ( ) _____

Cell ( ) _____ Email address: _____

Age: _____ Date of Birth: _____

Married: ____ Single: ____ List spouse, children and all other dependents currently living at home with the patient:

Name: _____ Age: _____ Date of Birth: _____

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How did you hear about CMF? _____

Please provide a brief summary of your illness and current circumstances/case:

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Date of diagnosis:_____ Primary Cancer:_____ Current Stage:_____

Prognosis: _____

☐ New diagnosis ☐ Recurrence **Is patient in active treatment?** ☐ Yes ☐ No

Please indicate type of treatment(s) received in the past twelve months (check all that apply)

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Other: _____

What is the projected length of treatment? _____

_____

*PLEASE INCLUDE A PHYSICIAN DIAGNOSIS VERIFICATION ON LETTERHEAD

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ☐ Yes ☐ No

Is spouse currently employed? ☐ Yes ☐ No

PATIENT INCOME SOURCES (please check all that apply):

☐ Social Security ☐ Salary ☐ Pension ☐ Unemployment
☐ Public Assistance ☐ SSD (Disability) ☐ SSI ☐ Short-term disability
☐ Spouse's Income ☐ Personal Income ☐ Family / friends provide support
☐ Other: _____

Have you applied and/or received assistance from other agencies? ☐ YES ☐ NO

If YES, which ones? _____

_____

What financial hardship do you have BECAUSE of your diagnosis of cancer?

_____

_____

_____

Did you work before your diagnosis? ☐ YES ☐ NO ☐ Part Time ☐ Full Time

Will you be able to return to work after your treatment? ☐ YES ☐ NO ☐ Part Time ☐ Full Time

If you will not be able to return to work as before, please explain the reason.

_____

_____

_____

Please mark what services would be beneficial –

Additional comments:

- Housecleaning ☐ _____
- Grocery/Delivery ☐ _____
- Errand Support ☐ _____
- Meal Support ☐ _____
- Financial Support ☐ _____
- Other-Please Specify ☐ _____

_____

_____

Incomplete applications cannot be accepted

THE CARIN MACLEAN FOUNDATION'S MISSION IS TO DIRECTLY HELP FAMILIES IN FINANCIAL NEED. WE SOUGHT TO KEEP OUR ORGANIZATION ON A CLOSE AND PERSONAL LEVEL FOR OUR RECIPIENTS. WE DO HAVE SOME REQUIREMENTS FOR RECIPIENTS, BUT SOLELY ON THE BASIS TO SPREAD AWARENESS OF CMF AND TO ACHIEVE OUR GOAL TO HELP AS MANY OF THOSE IN NEED. THEREFORE, WE RESPECTFULLY SHARE THE STORIES OF OUR RECIPIENTS IN ORDER TO STAY TRUE TO OUR MISSION. IF YOUR APPLICATION IS APPROVED, WE ASK THAT YOU SEND US A PHOTO, ANY ONE OF YOUR CHOICE, ALONG WITH YOUR JOURNEY TO DATE, IN ORDER TO KEEP BUILDING OUR COMMUNITY AND ALLOWING US TO PUT A FACE WITH THE STORY TO BE SHARED WITH SUPPORTERS AND OTHERS FACING THE SAME BATTLE. THE RECIPIENT'S STORIES WILL BE SHARED ON, BUT NOT LIMITED TO, SOCIAL MEDIA AND OUR WEBSITE TO HELP CONNECT WITH OTHERS. WE ASK THAT YOU LIKE US ON FACEBOOK AND ANY OTHER SOCIAL MEDIA TO INCREASE AWARENESS. WE WELCOME THE SUPPORT OF THE RECIPIENT'S FRIENDS AND FAMILY AT OUR FUNDRAISING EVENTS, AS TO BENEFIT YOU AND YOUR FIGHT. YOUR FAMILY AND FRIENDS ARE THE CLOSEST COMMUNITY OF SUPPORT YOU HAVE. PLEASE SIGN BELOW AGREEING TO THESE TERMS AND GIVING YOUR CONSENT TO THE CARIN MACLEAN FOUNDATION INC. TO SHARE YOUR STORY, TO BE PROVIDED FROM RECIPIENT OR RECIPIENT REPRESENTATIVE, IF GRANT IS PROVIDED.

_____

SIGNED DATE

I DO HEREBY CERTIFY THAT ALL STATEMENTS MADE BY ME IN THIS APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF, FURTHER, I UNDERSTAND THAT IN THE EVENT THAT I HAVE KNOWINGLY AND WILLFULLY MADE ANY FALSE STATEMENTS, I WILL BE LIABLE FOR PUNISHMENT IN ACCORDANCE WITH ALL APPLICABLE LAWS AND STATUES.

I CERTIFY THAT THE FOLLOWING ATTACHMENTS ARE INCLUDED WITH MY COMPLETED APPLICATION:

_____ COPY OF DRIVER'S LICENSE, STATE I.D., SS CARD OR PERMANENT RESIDENT CARD

_____ PHYSICIAN DIAGNOSIS VERIFICATION ON LETTERHEAD

_____

SIGNED DATE

ALL APPLICATIONS MUST BE SUBMITTED BY SOCIAL WORKER

Please be aware that funds are limited, based on availability as well as meeting Carin MacLean Foundation Inc.'s requirements.