LEND A HELPING HAND PROGRAM

The Lend a Helping Hand Program was created by the Great Neck Breast Cancer Coalition (GNBCC) to provide help to patients undergoing treatment for breast cancer. The focus of LAHH is to provide customized services to the patient to relieve some of the stress and worry a cancer diagnosis and ensuing treatment creates. Transportation to and from cancer-related medical appointments, housecleaning, and meals are just a few of the services that LAHH offers.

Eligibility in the LAHH program requires a patient to be currently undergoing surgery, chemotherapy and/or radiation therapy for breast cancer. Patients receiving only hormone therapy (Tamoxifen, Fermara, etc.) or Herceptin are not eligible. Patients are expected to utilize other sources of support and services and not rely solely on the LAHH program for assistance.

In order for the GNBCC to provide LAHH services, the attached application must be completed in its entirety. Please understand that GNBCC will be contacting your physician to confirm that you are in active treatment.

Upon receipt of your completed application and confirmation of your diagnosis and treatment protocol, a LAHH volunteer will contact you to discuss the specifics of your application and how the GNBCC may help you.

Nothing herein or associated with the LAHH services shall create any right on the part of any third party and not third party is intended to be any beneficiary of the LAHH program.

P.O. BOX 231190, GREAT NECK, NY 11023 • Tel: 516-829-1139 • Fax: 516-829-3915
AFFILIATED WITH THE LONG ISLAND JEWISH MEDICAL CENTER'S COMPREHENSIVE BREAST CENTER

SERVICES THAT LEND A HELPING HAND PROGRAM PROVIDES

(Participants must choose service providers)

House Cleaning

Home Care

Transportation to/from Medical Appointments

Child Care

Post-Mastectomy Accessory Items (Bras and Wigs)

Food shopping and/or food catering to the home

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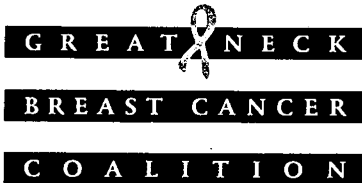

Date______________

LEND A HELPING HAND QUESTIONAIRE

In order for your request to receive full consideration, please complete this form. In addition, we will need a letter from your oncologist confirming your diagnosis and treatment. All information will be kept confidential.

Patient Information

Participant's Name:________________________________ Age:______

Address:____

Home Phone:__________________________ Work Phone:____________________

Cell Phone:___________________________ Email: ________________________

Single: ___________ Married________________

Number of children living at home_______ Ages:______________________

Medical Information

Referring Doctor:____

Other Doctors (Oncology, Radiology, Surgeon):______________________________

Chemo/Radiation Facility:____

Address: ____

Phone:______________________

Nurse/Social Worker/Contact Person:______________________________________

Medical Diagnosis:______________________________ Date of diagnosis:_________

Current treatment:____________________ Date treatment began or will begin:_____

Anticipated length of treatment________________________________

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GNBCC TERMS FOR LEND A HELPING HAND (LAHH) PROGRAM

The Great Neck Breast Cancer Coalition will not choose the names of the service providers for the LAHH program. The participant will choose the names of the service providers (such as taxi cab companies, home cleaning services, etc). GNBCC will provide limited funding for services upon receipt of specific vouchers or receipts from service providers.

The participant of LAHH hereby releases and agrees to hold the Great Neck Breast Cancer Coalition, its agents or members, harmless for, from and against any and all liability, damages and claims of any kind, known or unknown, including any act, contact or communication even if such constitutes ordinary negligence, which may be connected with, result from, arise in any way of the LAHH program or which would not have been occasion but for such program. This includes, but is not limited to, any problems with transportation, food and lodging, medical conditions, both physical and emotional, accidental injury and death.

I understand and agree that representatives of the GNBCC 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 GNBCC, as well as compliance with all conditions, qualifications and restrictions designated by the GNBCC. 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 "Terms" prior to signing it. Participant agrees that no modification of these Terms has been made orally or in writing and these Terms accurately and fully express the understanding of the participant.

Participant Signature____

Name: (please print) ____

Additional Signature (if participant is not able to sign) __________________________

Name: (please print) ____

Please return this signed form to the Great Neck Breast Cancer Coalition by email: info@greatneckbcc.org or by mail to: P.O. Box 231190, Great Neck, NY 11023

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) __________________ to (insert date) __________________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: ________________________________
  ____

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**
________ **Mental Health Information**
________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here ____________ I authorize ____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____ Date: ____________________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**