



## Carin MacLean Foundation Application for Assistance

The Carin MacLean Foundation is an independent 501(c)(3) nonprofit. We support mothers undergoing cancer treatment across New England in maintaining stability for their families by delivering financial relief and essential household assistance.

### **GUIDELINES FOR FINANCIAL ASSISTANCE:**

To qualify for the CMF Assistance Program, patient must:

1. **Live in the geographic area we serve** — Be a resident of Massachusetts, Rhode Island, Connecticut, New Hampshire, Maine, or Vermont, and be a U.S. citizen or a U.S. lawful permanent resident (green card holder).
2. **Be an adult female cancer patient with dependents** — Dependents must be children who live with the applicant and have not yet graduated high school (through 12<sup>th</sup> grade). \*With multiple children of different ages, you will qualify if at least one child living with you has not yet graduated high school.
3. **Be in active treatment at time of application** — Applicant is currently receiving oncology care (chemotherapy, radiation, surgery, or active surveillance) and is being followed by an oncology provider.
4. **Have demonstrated financial need related to diagnosis** — Including (but not limited to) excessive medical bills, wage loss, childcare, housecleaning, or transportation costs.
5. **Submit during the application window** — Applications are accepted July 1st through December 31st and must be submitted by a social worker. Funds are limited; meeting guidelines does not guarantee an award.

**Required attachments (please include):** physician diagnosis verification on letterhead & copy of ID (passport, green card, or state driver's license/ID).

**Confidentiality:** All materials are treated as confidential and stored securely.

Please send completed application to:  
Carin MacLean Foundation  
P.O. Box 81  
Seekonk, MA 02771  
or by email to:  
[contact@carinmacleanfoundation.org](mailto:contact@carinmacleanfoundation.org)

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

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: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**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):

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Social Security   | <input type="checkbox"/> Salary           | <input type="checkbox"/> Pension                          | <input type="checkbox"/> Unemployment          |
| <input type="checkbox"/> Public Assistance | <input type="checkbox"/> SSD (Disability) | <input type="checkbox"/> SSI                              | <input type="checkbox"/> Short-term disability |
| <input type="checkbox"/> Spouse's Income   | <input type="checkbox"/> Personal Income  | <input type="checkbox"/> Family / friends provide support |  |
| <input type="checkbox"/> 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Please mark what services would be beneficial -

Additional comments:

- Housecleaning  \_\_\_\_\_
- Grocery/Delivery  \_\_\_\_\_
- Errand Support  \_\_\_\_\_
- Meal Support  \_\_\_\_\_
- Financial Support  \_\_\_\_\_
- Other-Please Specify  \_\_\_\_\_

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**Incomplete applications cannot be accepted**

# Carin MacLean Foundation Application for Assistance

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The Carin MacLean Foundation is an independent 501(c)(3) nonprofit. Our mission is to support mothers undergoing cancer treatment across New England by providing financial relief and essential household assistance.

If your application is approved, you must provide a photo (your choice) and a brief account of your journey. We respectfully share recipients' stories to raise awareness of the Foundation's work and to connect with potential supporters. Materials provided (photos and story) may be used on the Foundation's website, social media channels, printed materials, and at fundraising events.

All documents you submit for eligibility verification (for example: physician verification, copies of ID) will be treated as confidential, accessed only by staff and the volunteer review committee, and stored securely. By signing below, you authorize the Carin MacLean Foundation to publish the photo and brief story you provide (for example, on our website, social media, printed materials, and at events). We will not publish sensitive personal data such as Social Security numbers, bank account details, or medical records.

If you prefer your story to be used anonymously or with identifying details removed, please note that preference on your submission and we will honor it.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Or, if an authorized representative signs on the applicant's behalf, please indicate relationship/role.)

I certify that I am a **U.S. citizen** or a **U.S. lawful permanent resident (green card holder)**.

Attach copy of one of the following:

- U.S. passport (photo page)
- Certificate of Naturalization / Certificate of Citizenship
- Permanent Resident Card (Form I-551) – front & back
- Driver's license or state ID

**Required:** Physician diagnosis verification on official letterhead.

By checking the box above and signing below, I certify that the information provided is true and accurate to the best of my knowledge. I understand that knowingly providing false information may affect my eligibility.

Applicant signature: \_\_\_\_\_ 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's requirements.**