

# BLESSED TO BLESS PROGRAM

Patient Application Form  
Free Home Cleaning for Cancer Patients

## Blessed Cleaning Services Corp.

Massapequa, NY | blessedcleaningservice.com | 917-362-3146

### SECTION 1: PATIENT INFORMATION

Full Name: _____	Date of Birth: _____	
Phone Number: _____	Email Address: _____	
Address: _____		
City: _____	State: _____	Zip: _____

Preferred Language:  English  Spanish  Other: \_\_\_\_\_  
Best Time to Contact:  Morning  Afternoon  Evening

### SECTION 2: CANCER DIAGNOSIS & TREATMENT

Type of Cancer: _____	Date of Diagnosis: _____
-----------------------	--------------------------

Current Treatment Status (check all that apply):

- Chemotherapy
- Radiation
- Immunotherapy
- Post-Surgery Recovery
- Hospice Care
- Recovering from Treatment (within 6 months)
- Other: \_\_\_\_\_

Treating Oncologist/Physician Name: \_\_\_\_\_

Hospital/Treatment Facility: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

### SECTION 3: HOUSEHOLD INFORMATION

Number of People in Household: _____	Do You Live Alone? (Yes/No): _____
Number of Bedrooms: _____	Number of Bathrooms: _____

Approximate Home Square Footage: \_\_\_\_\_

Do You Have Pets?  Yes (type: \_\_\_\_\_)  No

Mobility Limitations: \_\_\_\_\_

Allergies to Cleaning Products: \_\_\_\_\_

Special Cleaning Considerations: \_\_\_\_\_

### SECTION 4: HOW DID YOU HEAR ABOUT THIS PROGRAM?

- Massapequa Chamber of Commerce

- Town of Oyster Bay
- Doctor/Hospital Referral
- Facebook/Instagram
- Neighbor/Friend
- Community Organization
- Other: \_\_\_\_\_

**SECTION 5: APPLICANT CONSENT & ACKNOWLEDGMENT**

Please read and check each statement below:

- I confirm that all information provided in this application is true and accurate.
- I consent to Blessed Cleaning Services contacting my physician to verify my treatment status.
- I understand that selection is based on need and program capacity and is not guaranteed.
- I agree to allow cleaning professionals into my home on scheduled dates.
- I understand that all services are provided free of charge with no obligation.
- I consent to being contacted by Blessed Cleaning Services regarding my program status.
- I consent to my first name, picture and general areas being used for program announcements if selected.

**SECTION 6: PERSON SUBMITTING APPLICATION (IF NOT THE PATIENT)**

Relationship to Patient: _____	Full Name: _____
Phone Number: _____	Email Address: _____

- I confirm that the patient has consented to this application being submitted on their behalf.

**SIGNATURES**

Patient Signature: _____	Date: _____
Applicant Signature (if different): _____	Date: _____

**HOW TO SUBMIT**

- Email:** Blessedcleaningservices1@gmail.com
- Online:** blessedcleaningservice.com
- Phone:** 917-362-3146
- In Person:** Contact us to arrange

*Applications accepted on a rolling basis. All qualified applicants will be reviewed and contacted.*

## PHYSICIAN VERIFICATION FORM

Blessed to Bless Program  
Blessed Cleaning Services Corp.

Dear Healthcare Provider, please verify the following patient's cancer treatment status for the Blessed to Bless Program, which provides free home cleaning services to cancer patients in our community.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_

**Treatment Status** (*check one*):

- Currently undergoing active cancer treatment
- Recovering from cancer treatment (within the last 3 months)

Type of Treatment: \_\_\_\_\_

Approximate Treatment Dates: \_\_\_\_\_

### PHYSICIAN INFORMATION

Physician Name: \_\_\_\_\_

Practice/Hospital: \_\_\_\_\_

Phone: _____	Fax/Email: _____
--------------	------------------

Physician Signature: _____	Date: _____
----------------------------	-------------

#### RETURN INSTRUCTIONS

Email: [Blessedcleaningservices1@gmail.com](mailto:Blessedcleaningservices1@gmail.com)  
Fax or mail to: Blessed Cleaning Services Corp., Massapequa, NY  
Phone: 917-362-3146

*Thank you for supporting your patient through the Blessed to Bless Program.*