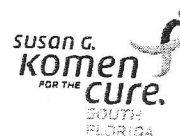




MAMMOGRAPHY FINANCIAL ASSISTANCE FORM



NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME # _____ WORK # _____ CELL # _____

DATE OF BIRTH _____ SSN # _____

EMPLOYER _____

DO YOU HAVE MEDICAID OR MEDICARE? ____ If Yes, which one? _____

DO YOU HAVE INSURANCE? ____ If Yes, List your INSURANCE CARRIER:

NAME OF DOCTOR: _____

(Physician to whom results can/will be mailed.)

DOCTORS ADDRESS _____

DOCTOR'S PHONE _____

of people in Household _____ Proof of Residency _____

(attach copy)

of children under 18 _____

GROSS TOTAL FAMILY INCOME _____ last 12 months

Date of Last Mammogram _____ Where: _____

I, the undersigned, hereby apply for financial assistance for a mammogram (breast x-ray) and certify that the information provided by me contained herein is true, accurate and correct to the best of my knowledge. I hereby give consent to verify all statements made on this form.

Signature of Responsible Party

Date

Signature of Witness

Date

Race: ____ African American ____ Hispanic ____ Asian ____ Caucasian ____ Other