AlphonseBreastCancer.Foundation * info@alphonsebreastcancer.foundation

Screening Mammography Application

Application for assistance is based on need for **screening mammography** services and the inability to pay for such service through insurance or self-pay. Funds are available for screening mammograms only. Application for assistance will be individually evaluated after the completion of this form. All questions must be answered.

Name: _____ Date of Birth: _____

Age: _____ Gender: _____ Race: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ E-Mail: _____

Employment status: _____

Health Coverage: Yes No

If Yes, circle one: personal policy employer policy Medicare Medicaid

Household size: _____

Estimated Annual household income: _____

Emergency contact: _____ Relationship to you: _____

All information is considered confidential and will be used only for eligibility determination. Applications will be reviewed on a monthly basis and evaluated to provide assistance to those with the greatest need. **Funding is only provided for screening mammograms. If additional diagnostic testing is required as a result of the initial screening mammogram, ABCF is in no way obligated to provide financial assistance for such service.**

I hereby declare that the information provided in this form is true and correct. I also understand that UCSF will reserve the right for final decision of the application and to decline application without providing any explanation.

Signature _____ Date _____

ALPHONSE BREAST CANCER FOUNDATION
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HISTORY AND PATIENT INFORMATION FORM APPLICANT

NAME:_____

WHO REFERRED YOU TO ABCF?_____

HAVE YOU HAD A CLINICAL BREAST EXAM IN THE LAST YEAR? YES NO

IF YES, WHEN?_____

RESULTS: Normal Suspicious OTHER:_____

HAVE YOU RECEIVED A SCREENING MAMMOGRAM FROM UCSF IN THE PAST?: YES NO

PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS: BREAST LUMP DISCHARGE FROM NIPPLE PAIN OTHER:_____

DO YOU HAVE HEALTH INSURANCE? YES NO

DO YOU HAVE MEDICARE OR MEDICAID? YES NO

IF YES, DO YOU HAVE MAMMOGRAPHY COVERAGE? YES NO

IF YES, WHAT TYPE?_____

IF MARRIED, ARE YOU COVERED ON SPOUSE'S INSURANCE PLAN? YES NO

IF YES, DO YOU HAVE MAMMOGRAPHY COVERAGE?_____

HAVE YOU EVER HAD A MAMMOGRAM? YES NO

IF YES, WHEN WAS YOUR LAST MAMMOGRAM?_____

DO YOU HAVE MEDICAID? YES NO

IF NOT, ARE YOU APPLYING FOR IT? YES NO

DO YOU HAVE A HISTORY OF CANCER? YES NO

IF YES, WHAT TYPE AND WHEN?_____

DO YOU HAVE A FAMILY HISTORY OF CANCER? YES NO

IF YES, WHO AND WHAT TYPE?_____