

**BREAST CANCER FOUNDATION OF THE OZARKS  
APPLICATION FOR SCREENING MAMMOGRAPHY ASSISTANCE**

**Made possible by a grant from the Missouri Foundation for Health**

Application for assistance is based on need for 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 by our organization after the completion of this form. **All questions must be answered.**

Name: _____	D.O.B: _____	SS#: _____
Address: _____	City: _____	Zip: _____
Telephone No.: _____	Email: _____	County: _____
Spouse: _____	Children & Ages: _____	Other Dependents: _____
Employer: _____	Date of last Clinical breast exam: _____	Physician: _____

**Health Coverage:**  No  Yes If yes, Circle TYPE: Personal Policy, Through Employer, Medicare, Medicaid  
Referred to BCFO by: \_\_\_\_\_

**FINANCIAL INFORMATION:**

		<u>Monthly Income</u>	<u>Estimated Monthly Expenses</u>
Employment:	Patient:	\$ _____	Rent/Mortgage: \$ _____
	Spouse:	\$ _____	Utilities: \$ _____
	Other:	\$ _____	Food: \$ _____
Retirement:	Social Security:	\$ _____	Insurance Health: \$ _____
	VA Pension:	\$ _____	Insurance Home: \$ _____
	Employee Pension:	\$ _____	Insurance Car: \$ _____
Other Income:	Alimony:	\$ _____	Medical: \$ _____
	Child Support:	\$ _____	Auto Payment: \$ _____
	Investments:	\$ _____	Credit Card Debt \$ _____
	Public Assistance:	\$ _____	Other Expenses: _____
	Workmen's Comp:	\$ _____	
	Unemployment:	\$ _____	
	Disability:	\$ _____	TOTAL: \$ _____
	Insurance:	\$ _____	*You may be required to submit
Savings:	\$ _____	financial documentation such as tax	
Assets: (If more space needed, please attach separate sheet)			returns or bank records
_____			Value
_____			_____

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, BCFO is in no way obligated to provide financial assistance for such service.

I agree that the above-mentioned information is correct to the best of my knowledge. I further agree that if my request is approved, I will comply with the request of BCFO to supply a copy of my mammography results and other medical documentation pertaining to this service for statistical and research purposes.

\_\_\_\_\_  
Date

\_\_\_\_\_  
APPLICANT SIGNATURE

**PLEASE RETURN TO:** 330 North Jefferson, Suite B Springfield, Missouri 65806 OR fax 417-862-3830  
**CALL:** (417) 862-3838 or toll free 1-866-874-1915 for answers to questions in reference to this form.

**Medical History Form**

APPLICANT NAME: \_\_\_\_\_

WHO REFERRED YOU TO BCFO: \_\_\_\_\_

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

IF YES, WHEN? \_\_\_\_\_ RESULTS: Normal Suspicious OTHER

PLEASE DEFINE OTHER: \_\_\_\_\_

**IF YOU HAVE HAD AN ABNORMAL CLINICAL BREAST EXAM, HAVE A LUMP, OR ANY ABNORMALITY IN YOUR BREASTS, YOU MAY REQUIRE DIAGNOSTIC SERVICES, AND WILL NOT QUALIFY FOR A SCREENING MAMMOGRAM THROUGH BCFO. BCFO ONLY PROVIDES SCREENING MAMMOGRAM SERVICES DUE TO OUR LIMITED, GRANT FUNDED PROGRAM. PLEASE CONTACT US IF YOU HAVE ANY ABNORMALTY FOR A REFERRAL TO A PROGRAM THAT MAY BE ABLE TO ASSIST YOU.**

HAVE YOU RECEIVED A SCREENING MAMMOGRAM FROM BCFO IN THE PAST? PLEASE CIRCLE ONE: YES NO

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

PLEASE DEFINE OTHER: \_\_\_\_\_

SCREENING PLACE OF CHOICE: \_\_\_\_\_

DO YOU HAVE HEALTH INSURANCE? YES NO

IF YES, DO YOU HAVE MAMMOGRAPHY COVERAGE?: YES NO

IF YES, WHAT TYPE? \_\_\_\_\_

IF MARRIED, ARE YOU COVERED ON SPOUSE'S INS. 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? \_\_\_\_\_

ARE YOU A CLIENT OF SHOW ME HEALTHY WOMEN? YES NO

