SCREENING MAMMOGRAPHY APPLICATION
BREAST CANCER FOUNDATION OF THE OZARKS

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: _____ 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 one: Personal Policy, Employer Policy, Medicare, Medicaid

Referred to BCFO by: _____

FINANCIAL INFORMATION:

		Monthly Income		Estimated Monthly Expenses	
Employment:	Patient:	$_____	Rent/Mortgage	$_____	
	Spouse	$_____	Utilities	$_____	
	Other:	$_____	Food	$_____	
Retirement:	Social Security:	$_____	Health Insurance	$_____	
	VA Pension:	$_____	Homeowners Ins	$_____	
	Employee Pension:	$_____	Car Insurance	$_____	
Other Income:	Alimony:	$_____	Medical	$_____	
	Child Support:	$_____	Auto Payment	$_____	
	Investments:	$_____	Credit Card Debt	$_____	
	Public Assistance:	$_____	Other Expenses		
	Workmen's Comp:	$_____	$_____		
	Unemployment:	$_____			
	Disability:	$_____			
	Insurance:	$_____	TOTAL:	$_____	
	Savings:	$_____			

*You may be required to submit financial documentation such as tax returns or bank records

Assets: (If more space needed, please attach separate sheet) 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: 620 W. Republic Rd., Ste. 107 Springfield, MO 65807 OR fax 417-862-3830

CALL: (417) 862-3838 for answers to questions in reference to this form.

HISTORY AND PATIENT INFORMATION 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:_____

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:_____

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 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

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: _____
Name of Healthcare Facility

_ _____
Street Address

_____
City, State and Zip Code

RE: _____
Patient Name

_____
Street Address

_____
City, State and Zip Code

_____
Telephone number

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with documenting my medical care and treatment. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All pertinent documentation and medical records including: history and physical, discharge summary, operative reports, consultation reports, lab results, progress notes, pathology reports, pharmacy/prescription records and any other pertinent documentation.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse, psychiatric care or other sensitive information. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of review, determination and consultation of program eligibility with Breast Cancer Foundation of the Ozarks and should be sent to:

Breast Cancer Foundation of the Ozarks
620 W. Republic Rd., Ste. 107
Springfield, Missouri 65807

Phone Number: 417-862-3838
Fax Number: 417-862-3830

Further, I understand:
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. I understand that this authorization is voluntary but is also a condition of eligibility for Breast Cancer Foundation of the Ozarks program and that without a signed authorization for the release of patient information, I will not be eligible for assistance.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

_____ _____
Patient Signature Date

_____
Printed Name of Patient