6700 Baum Drive Suite 8 Knoxville, TN • Phone: (865) 474-1551 • Email: info@unitedcsf.org

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. (*Note: This free service is currently not available in following states: Michigan, Minnesota, New York, Iowa and Oregon.)*

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, UCSF 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 _________________________

6700 Baum Drive Suite 8 Knoxville, TN • Phone: (865) 474-1551 • Email: info@unitedcsf.org

HISTORY AND PATIENT INFORMATION FORM

APPLICANT NAME:____

WHO REFERRED YOU TO UCSF?____

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?____