UNITED WE CARE UNITED WE SHARE

UNITED CANCER SUPPORT FOUNDATION

AMERICAN BREAST CANCER SUPPORT ASSOCIATION

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

MAMMOGRAPHY FUND APPLICATION

PARTICIPANT INFORMATION	**Please PRINT PLAINLY**			
First Name:	Middle Name:	Last Name:		
Birth Date: / /	Age:	Circle Gender: F M	Race:	Language:
Home Street Address:				
City:	State:	Zip Code		
Home Phone:	Cell Phone:	Email:		
Print Friend or Family Member's Name & Phone No:	Household Size (circle # of people living in your household): 1 2 3 4 5 6 7 8 9 10 11 12			
Total income from ***all*** people living in your household: $				
Has *United Cancer Support Foundation* assisted you in the past? (check one) ☐ No ☐ Yes (provide year & how assisted)				
Interpreter's Name (if any):	Interpreter's Phone:			
HEALTH INSURANCE INFORMATION				
(check one): ☐ I do ***not*** have health insurance. ☐ I ***do*** have health insurance. (complete below insurance question.)				
Insurance Provider's Name (if applicable):				
PRIMARY CARE PHYSICIAN INFORMATION				
(Check one) ☐ I do ***not*** have a primary care physician. ☐ I ***do*** have a primary care physician (complete below info)				
Physician's Name:	Office Phone:			
Office Address:				
City:	State:	Zip Code:		
SCREENING & FAMILY HISTORY				
(check one): ☐ *No family history* of breast cancer. ☐ *Family history* of breast cancer.				
I have had a mammogram. (check one) ☐ Yes ☐ No	If yes, date done:	If yes, name of facility:		

AGREEMENT

1. I hereby declare that the information provided in this form is true and correct.
2. I understand that all information submitted to the *United Cancer Support Foundation* (*UCSF*) will be kept strictly confidential.
3. I understand that *UCSF* reserves the right for final decision on the approval of this application and to decline the application without providing any explanation.
4. I understand that *UCSF* reserves the right to decline the application without providing any explanation.
5. I understand that I am responsible for attending all scheduled screening appointments.
6. I understand that applicants are contacted in the order applications are received.
7. I understand that applications are held for three months only and a new application is required if *UCSF* is unable to reach me by phone or mail during this time.

Participant's Printed Name:

Participant's Signature **Date / /**

Mail completed application to

United Cancer Support Foundation, 6700 Baum Drive, Suite 8, Knoxville, TN 37919, Attn: Program Services Coordinator

or email to *mammogram@unitedcsf.org*.

FOR OFFICE USE ONLY		
Application number ____ of ____ applications for this person & number ____ of ____ mammogram(s) approved.		
Date application ☐ mailed ☐ emailed:		Date application received:
Date Denied:	Staff Initials:	Reason:

Date Approved:	Staff Initials:	
Type of Testing Approved: ☐ Classic ☐ Screening ☐ Diagnostic ☐ 3D ☐ Ultrasound ☐ Other:		
Appointment Date:	Time:	Facility:
Appointment Date:	Time:	Facility:
Follow-up Required: ☐ No ☐ Yes (check one) ☐ Classic ☐ Screening ☐ Diagnostic ☐ 3D ☐ Ultrasound ☐ Other:		
Method of Transportation (Check one): ☐ Drive Self ☐ Friend/Family ☐ City Bus ☐ CAC Shuttle ☐ Taxi ☐ Uber/Lift ☐ Other:		

Date Approved:	Staff Initials:	
Type of Testing Approved: ☐ Classic ☐ Screening ☐ Diagnostic ☐ 3D ☐ Ultrasound ☐ Other:		
Appointment Date:	Time:	Facility:
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Follow-up Required: ☐ No ☐ Yes (check one) ☐ Classic ☐ Screening ☐ Diagnostic ☐ 3D ☐ Ultrasound ☐ Other:		
Method of Transportation (Check one): ☐ Drive Self ☐ Friend/Family ☐ City Bus ☐ CAC Shuttle ☐ Taxi ☐ Uber/Lift ☐ Other:		

Date: _____ Time: _____ ☐ Made Contact ☐ Left Message ☐ Not Interested ☐ Disconnected COMMENTS: _____ _____
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Created 9/13/18