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

Thank you for trusting the American Breast Cancer Support Association (ABCSA) and the *United Cancer Support Foundation* (UCSF) for mammogram service. We are here to serve you. Once your application is complete, you can return it by mail or e-mail to *mammogram@unitedcsf.org*. Below is the information needed to help you complete the process of scheduling your mammogram.

While your application is in process, outlined below are additional steps you should complete. It is your responsibility to schedule your mammogram appointment with a date and time that is convenient for you.

1. Please mail your completed application to the United Cancer Support Foundation at 6700 Baum Drive, Suite 8, Knoxville, TN 37919, Attention: Mammogram and Facilities Coordinator, or e-mail it to *mammogram@unitedcsf.org*. ***UCSF does not have a fax line.***

2. Locate a facility in your area where you wish to have your mammogram.

3. Furnish us the name, address, and phone number of the facility you have chosen. ***To pay for mammogram services, we need to speak with their billing department before scheduling your appointment unless the facility states otherwise.*** (Please note that we request billing invoices only, ***not*** your results. We pay the facility direct)

Once financial arrangements are complete, A UCSF representative will give you a call and e-mail you a copy of the paid mammogram receipt. If you have any questions during or after this process, please call 865.474.1551 for more information.

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Screening Mammography Application

The inability to pay should not prevent you from receiving preventive care. If you are uninsured or underinsured, the United Cancer Support Foundation can assist you with getting a mammogram at no cost to you. To receive a quicker response, please answer all questions. If you have any questions, please give us a call at 865.474.1511. Funds are only available for mammograms (screening or diagnostic). ***(Note: This free service is currently not available in the following states: Michigan, Minnesota, New York, Iowa, Oregon, and Utah.)***

Name: _____ **Date of Birth**: _____

Age: _____ **Gender**: _____ **Health Coverage**: **Yes** **No**

If covered, circle one for type : ***personal policy*** ***employer policy*** ***Medicare*** ***Medicaid***

Home Address: _____

City: _____ **State**: _____**Zip**: _____

Phone #: _____ **E-Mail**: _____

Race\Ethnicity (Check One)

☐ Hispanic or Latino ☐ Asian ☐ American Indian or Alaska Native
☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Are you currently employed? ☐ **Yes** ☐ **No** **Annual household income**: $_____

Household size: _____**Emergency contact**: _____

Relationship to you: _____

All information is confidential and used to determine eligibility. If approved, all payments are made directly to **imaging** and **radiology** providers. Submission of this application does not imply or guarantee approval of financial assistance. Applications are reviewed and evaluated to aid those with the greatest need.

□ I declare that the information provided in this form is true and correct.
□ I understand UCSF reserves the right to decline my application without explanation.

Signature _____ **Date** _____

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HISTORY AND CLIENT INFORMATION FORM

1. How did you hear about UCSF or American Breast Cancer Support Association?

   _____

   Have you received a mammogram from UCSF or ABCSA in the past? Yes No

   If yes, when was your last mammogram?_____

   Results: Normal Suspicious Other:_____

2. Have you had a clinical breast exam in the last year? Yes No

3. *Please circle if you have any of the following symptoms:

   Breast lump Discharge from nipple Pain Other:_____

*If you have any of these symptoms, you need to have a doctor's order from your physician or local health department.

4. Do you have a history of cancer? Yes No

   If yes, what type and when?_____

5. Do you have a family history of cancer? Yes No

   If yes, who and what type? _____

6. How have you been impacted by COVID-19?

   ☐ Lost Job ☐ Lost Health Insurance ☐ Contracted Coronavirus
   ☐ Had a treatment plan change ☐ Other _____

Internal Use Only:

Date Application Received: _____

Updated: 4/14/2022