

**HERITAGE HEALTH BREAST HEALTH ASSISTANCE PROGRAM**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exam Needed:

* Mammogram
* Breast Biopsy
* Breast Ultrasound
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am requesting the assistance of Heritage Health Center with payment for the service marked above and I do not qualify for other assistance programs\*. I understand the approval or denial of the assistance is based on my household income and/or proof of need. I understand I need to provide Heritage Health Center with proof of income. If I have insurance I must show proof my deductible is high and I cannot afford the cost of service. I also understand Heritage Health Center will pay directly to rendering provider\*.

Mark the document(s) proving income and/or need:

* Pay stubs (for every member of the household)
* W-2
* Unemployment
* Social Security Check
* Copy of Insurance Policy
* \*Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Pending approval of HHC Staff and fund availability.

\*Bill from rendering provider must be provided and funds will be paid directly to the medical service provider.

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Patient’s Signature Date

For Office Use Only: Approved Denied

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_