FREE MAMMOGRAM PROGRAM CLIENT APPLICATION

(FOR OFFICE USE ONLY)

Last Name: ______________________________ First Name: ____________________________

Home Mailing Address: ____

City: ____________________ State: __________________ Zip: __________________________

Date of Birth: ____________________ Phone #: _______________________________________

Social Security#:____________________________________

Please check what is applicable for your application:

- ☐ I cannot afford a mammogram
- ☐ I do not have health insurance
- ☐ I have health insurance and still cannot afford a mammogram due to high deductibles
- ☐ I have health insurance and it does not cover mammograms

Client Signature: ________________________________ Date/Time: ___________ /___________

- ☐ The information I provide on this form is correct and I wish to receive a free basic mammography and read through Teton Valley Health Care.

Emergency Contact Information: __________________________ Phone:___________________

All information provided is confidential.

OPTIONAL

What language do you prefer?

- ☐ English
- ☐ Spanish

How did you hear about this program?
(Please check all that apply)

- ☐ Health Care Provider
- ☐ District 7 Health
- ☐ Community Event/ Health Fair
- ☐ Radio/Newspaper
- ☐ Website
- ☐ Friend /Relative
- ☐ ________

What race do you consider yourself?

- ☐ White
- ☐ Hispanic
- ☐ Black / African American
- ☐ Asian
- ☐ Pacific Islander or Native American
- ☐ American Indian or Alaska Native
- ☐ Rather not say
- ☐ ________

Internal Use Only:

- ☐ Client meets requirements
- ☐ Mammo scheduled for:________
- ☐ Paperwork routed to TVH & Billing