MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
Phone: 812.934.6624

INDIANA BREAST CANCER AWARENESS HOPE
INDIANA BREAST CANCER AWARENESS TRUST

MAMMOGRAM ASSISTANCE PROGRAM - FOR OFFICE USE ONLY

Name: _____ Date: _____
Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Social Security Number: _____ Primary Care Provider: _____
Have you ever had a mammogram? ❒ Yes ❒ No If yes, date: _____
If date is unknown, please select time frame: ❒ Less than 1 year ❒ 1 year ❒ 2 years ❒ 3+ years
Facility where your mammogram was completed: _____

1. Patient Age: _____ Date of Birth: _____

❒ **40 years of age or older**
❒ **35 to 40 years of age (No clinical symptoms)**
  ❒ Is this your first mammogram? (If no, not eligible for mammogram program)
❒ **Less than 35 years of age (No clinical symptoms)**
  ❒ Is she considered high risk?
    • Mother or sister has/had breast cancer
    • Full chest radiation
  ❒ Is eligible for a mammogram 10 years before mother or sister received breast cancer diagnosis
  ❒ Must have physician order - if necessary can be referred to SEIHC

2. Insurance
❒ No Insurance

3. Residence
❒ Do you live within the MMH service area? If yes, select area.

❒ Batesville (47006)
❒ Brookville/St.Leon (47012)
❒ Cedar Grove (47016)
❒ Clarksburg (47225)
❒ Cross Plains (47017)
❒ Dillsboro (47018)
❒ Friendship (47021)
❒ Greensburg (47240)
❒ Guilford (47022)
❒ Holton (47023)
❒ Laurel (47024)
❒ Metamora (47030)
❒ Milan (47031)
❒ Millhousen (47261)
❒ Moores Hill (47032)
❒ Morris (47033
❒ Napoleon (47034)
❒ New Point (47263)
❒ New Trenton (47035)
❒ Oldenburg (47036)
❒ Osgood (47037)
❒ Sunman (47041)
❒ Versailles (47042)
❒ West Harrison (47060)
❒ Westport (47283)

3. Residence
• If patient lives in our service area, move to Question 4
OR
• Sees an MMH provider: _____

4. Income (See chart at right)

Family Size	Income Guidelines
1	$38,640
2	$52,260
3	$65,880
4	$79,500
5	$93,120
6	$106,740
7	$120,360
8	$133,980

Does this individual pre-qualify for mammogram assistance? ❒ Yes ❒ No
Mailed application for verification: _____

MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
Phone: 812.934.6624

INDIANA BREAST CANCER AWARENESS HOPE
INDIANA BREAST CANCER AWARENESS TRUST

MAMMOGRAM ASSISTANCE PROGRAM

Margaret Mary Health provides assistance to those eligible for mammogram screenings. If you believe you are eligible for assistance in paying for a mammogram screening, please complete the application. Should your application be considered, you may qualify for a free screening mammogram.

Because this specific program is grant-funded through MMH, and grant dollars change annually, should you need a mammogram screening in following years, you MUST re-apply for assistance. Additionally, grant monies are only used for screening mammograms. Should you need a diagnostic mammogram, you will need to re-apply to our Charity Care Program.

You will need to attach the following to your completed application:

- W2 or 1099 Form (last calendar year)
- Past three most recent paychecks
- Federal Income Tax Return (most recent)
- Income check (disability, compensation, unemployment, etc.)
- Any other data which might aid in processing your application

Margaret Mary utilizes the Federal Income Guidelines times 300% and below to determine our eligibility criteria. Your gross yearly income, as calculated from the information supplied and verified from your application, is compared to the appropriate income level category listed below.

Family Size	Income Guidelines
1	$38,640
2	$52,260
3	$65,880
4	$79,500
5	$93,120
6	$106,740
7	$120,360
8	$133,980

Please return your completed application to:

Margaret Mary Health
Attn: Meg Applegate - Community Health Improvement • P.O. Box 226 • Batesville, IN 47006

MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
Phone: 812.934.6624

INDIANA HOPE
BREAST CANCER AWARENESS
INDIANA BREAST CANCER AWARENESS TRUST

MAMMOGRAM ASSISTANCE APPLICATION

Name: _____ Date: _____

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Number of People In Your Home: _____

Family Member's Name	Age	Relationship	Employer Phone Number	Pay Frequency

Do you have another source of income? ❒ Yes ❒ No If yes, please explain: _____

Do you have health insurance? ❒ Yes ❒ No

I understand the information I submit is subject to verification by Margaret Mary Health and subject to review by federal and/or state enforcement agencies and others as required. Under penalty of perjury, I affirm the above information is true and accurate. I understand I must cooperate and provide all requested information to the Community Health Improvement Department concerning my Mammogram Assistance application. I also understand if I fail to provide the requested information, my application will not be processed.

Applicant Signature: _____ Date: _____

Internal Use Only

Verified Household Income: _____ Total Income: _____

Does this individual qualify for the Mammogram Assistance Program? ❒ Yes ❒ No