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.

_____ _____

Patient's Signature Date

For Office Use Only: _____Approved _____Denied

By: _____ Date: _____