FAIRCHILD FOUNDATION BREAST CANCER / MAMMOGRAM FUND APPLICATION

Purpose

The purpose of the Fairchild Medical Center Breast Cancer Fund is to provide limited payments for breast cancer screening. These monies are to be used by women (or men) who do not qualify for other financial aid programs due to age, medical history, uninsured, underinsured or are without sufficient funds to cover the services.

Sponsoring Groups

This fund is sponsored and supported by Fairchild Medical Center and Radiologists Dr. Michael Maloney, Dr. Rebecca Dyson and Dr. Peter Halt.

Funding Groups

Funds for the Fairchild Medical Center Foundation Breast Cancer Fund are obtained through FMC Foundation fundraising activities and Chevron Gas Station Patrons.

Criteria

- Patients must have household income at or below 200% of the Federal poverty level.
- Patient must be uninsured or underinsured -
- Patient has only Medicare part A
- Or Patient has Medi-Cal with benefit restrictions
- Or Patient has Medi-Cal with an unmet share of cost
- Or Patient has private insurance with barriers such as restricted benefits, large deductibles, or co-payments

Breast Imaging must be done at Fairchild Medical Center.
Patients must reside in Siskiyou County.

Procedure

Upon completion of the Breast Cancer Fund application form, Fairchild Medical Center and FMCF will review patient income and establish eligibility for the Breast Cancer Program. Fairchild Medical Center assumes no responsibility in validating accuracy or reported income by patient. Subsequent payment processing is handled by Claire Anstead, Executive Director of the Fairchild Medical Center Foundation.

FOUNDATION FUNDS FOR PATIENT CARE

Dear Patient and/or Family Member:

To be considered for assistance from Fairchild Medical Center Foundation Funds, please complete the attached financial questionnaire and brief statement of need. Return to Fairchild Medical Center Foundation.

Specific Fund or Program:

BREAST CANCER / MAMMOGRAM FUND

Qualification and approval is only for the specified service of:
Digital Mammogram, Mammogram Screening, Mammogram Diagnostic, Breast Ultrasound or Breast MRI.

Disclaimer: The attached Financial Questionnaire – Foundation Funds for Patient Care can only be utilized on a one-time basis per year to request assistance from the specified Fund and only for the services listed.

1. Full name

2. Date of birth

3. Phone number

4. Email

5. Address

6. City

7. State

8. ZIP Code

9. **Physician Name**

10. **Does the patient or family have health insurance? Name of Carrier**

11. **Number of People in Household. Ages of Children in Household.**

12. **Total monthly household income.**

13. **Total last 12 months income.**

14. **Do you reside in Siskiyou County?**

- ◯ Yes
- ◯ No
- ◯ Maybe

15. **Statement of Need – Please write a brief statement on how this scholarship will help you or the patient.**

16. **Signature** (By signing this form I agree to allow Fairchild Medical Center to check employment and credit history for the purpose of determining my eligibility for financial discount. I understand that I may be required to provide proof of the information I am providing. I understand that if the information is determined to be false, the documentation will result in a denial for services.)

17. **Date Signed**