MAMMOGRAPHY FUND

Purpose

The purpose of the Fairchild Medical Center Mammography Fund is to provide limited payments for mammography screening. These monies are to be used by women (or men) who do not qualify for other financial aide 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 and Dr. Peter Halt.

Funding Groups

Funds for the Fairchild Medical Center Mammography Fund are obtained through fundraising activities in the community such as Breast Cancer Bingo, Yreka Breast Cancer Walk and Chevron Gas Station Patrons.

Criteria

- A formal referral for services must be initiated by the patient's physician.
- Patient 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

Mammogram screening must be done at Fairchild Medical Center.
Patients must reside in Siskiyou County.

Procedure

A referral for services must be initiated by the patient's physician to Fairchild Medical Center. Upon completion of the Mammography Fund application form, Fairchild Medical Center will review patient income and establish eligibility for the Mammography Program. Fairchild Medical Center assumes no responsibility in validating accuracy or reported income by patient. Subsequent payment processing is handled by Elizabeth Langford, Executive Director of the Fairchild Medical Center Foundation.

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 provide proof of income (IRS 1040, pay stubs, etc.). Return to Fairchild Medical Center Foundation.

Specific Fund or Program:

MAMMOGRAPHY FUND

Qualification and approval is only for the specified service of: Digital Mammogram

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.

Patient Signature	Date
Patient Name (please print)	Date of Birth
Address	Social Security
City, State, Zip	Telephone Number
Physician Name	

Submitted by	Date
Approved by	Date

FAIRCHILD MEDICAL CENTER | FOUNDATION

Financial Questionnaire – Foundation Funds for Patient Care

Return to: Fairchild Medical Center Foundation
444 Bruce Street
Yreka, CA 96097

Please answer the questions below as completely as possible. All information will be kept confidential.

Patient's Name Last First M.I. ______________________ Social Security Number ______________________

Street Address City State Zip ______________________ Date of Birth ______________________

Does patient or family have health insurance? Name of Carrier ______________________ Telephone Numbers ______________________

Names of People in Household ______________________ Ages of Children in Household ______________________

Total monthly household income ______________________ Total last 12 months income ______________________

Do you reside in Siskiyou County? ______________________

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.

Signature:______________________ Date:______________________