Libby's Legacy Breast Cancer Foundation (LLBCF)

1718 S. Orange Ave, Orlando, Fl 32806
Ph (407) 898-1991 www.libbyslegacy.org
Fax (407) 841-4451

Application for Services

LLBCF uses the following information to help determine need for free mammograms.
All information is kept confidential, unless otherwise stated.

Date: _____ Name: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Please check your status: Citizen____ Resident____ Visa____ Undocumented____

Address: _____
Street Apt# City State Zip County

Home Ph _____/_____ Cell Ph _____/_____Work Ph ____/_____

Best # to call: Home / Cell / Work Best time to call: Morning / Afternoon / Evening

Email address: _____ Do you have access to computer? Y/N
Preferred method of contact: Email / phone call / letter

Ethnicity/Race: _____ **Who referred you to us today?** _____

Are you currently employed? Y/N Do you work: part-time / full-time
If yes, who is your employer? _____

Reason for unemployment? _____Year last worked_____

Do you have insurance? Y/N _____Referring Physician/clinic_____
Clinic address/ph _____
You MUST have a prescription for a mammogram to qualify for this service, do you? Y/N

Date of last mammogram: _____Do you have your films? Y/N If No, **Please call prior facility to pick up films**
If you've had a prior mammogram, please list the name of the Radiology Center along with their address & phone:
_____

Are you having symptoms? Y/N Describe symptoms:_____

Do you do monthly breast self-exams? Y/N Do you know how? Y/N Would you like education on breast health? Y/N

Family history of breast cancer? Y/N Who had it?_____ How old were they @ diagnosis?_____

Do you have a personal history of breast cancer? Y/N If yes, when were you diagnosed_____

Household Income: Self $_____/(**week or month or year?)** Partner $ _____/ (wk/mo/yr?)
Other $ _____ Food stamps$_____ (include job income, unemployment, SSI, child support, alimony, etc…)
Rent/Mortgage $_____/month # adults in household _____ #kids in household _____
(list ages: _____)

NOTE:
If you are between the ages of 50-64, please call the BCCEDP office @ 407-665-3185(Spanish) OR 407-665-3244 (English) to request a free mammogram. Please note any information obtained from them here:
Date called _____ Spoke with: _____Status: (on wait list or offered mammogram, etc.) _____
_____

Your Emergency Contact : _____ Relationship: _____
Phone: ____/_____

Along with your application we need the following documents- please make sure copies are LEGIBLE

- Copy of your Photo ID
- Your income documentation
  (Income documentation may be 3 paycheck stubs, tax returns from last year, a retirement benefit statement, alimony and child support, social security, unemployment, child support, etc. Please be sure to provide up-to-date infromation)
- Income documentation for your partner
- Income documentation for anyone else in your household
- Prescription/referral

Patient's Statement of Understanding

I have read and understand the above and declare the information furnished by me is true and complete to the best of my knowledge. I consent to the exchange of information between Libby's Legacy Breast Cancer Foundation and other community agencies to provide needed services.

_____
Signature of Patient / Responsible Party

_____
Date

I hereby authorize Libby's Legacy Breast Cancer Foundation to disclose appropriate medical information regarding my care to my referring agency, (agency name) _____ .

_____
Signature of Patient / Responsible Party

_____
Date

Filled out by LLBCF Staff: _____ Via: Phone / Walk-in Date_____

App rec'd on _____Via: FAX / MAIL / Walk-in Reviewed by_____ Date_____