Libby's Legacy Breast Cancer Foundation
1718 S. Orange Ave, Orlando, Fl 32806
Phone: 407.898.1991 □ Fax: 407.841.4451
info@libbyslegacy.org □ www.libbyslegacy.org

Application for Mammogram

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

Date: _____ Name: _____

DOB: _____ /_____ /_____ Age: _____

Please check your status: Citizen _____ Resident _____ Visa _____ Undocumented _____

Address: _____

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?** _____

Have you ever used Libby's Legacy for breast health services? Y/N

Are you currently employed? Y/N Do you work: part-time / full-time

If yes, who is your employer? _____

If you are not working, why not? _____ 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 name of the Radiology Center along with their address & phone:
_____

Are you having symptoms? Y/N Describe symptom:_____
Do you have implants? Y/N
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?_____

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

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

Service Eligibility & Release of Information Form
We need these documents- please send LEGIBLE copies with your application:

- Copy of Photo ID _____ - please make sure it is legible
- Copy of W-2 or last year's tax return _____
- Last 3 pay stubs (if you don't have W-2 or tax return) _____
- Prescription or referral from Dr/Clinic _____

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) _____ .

_____
Patient / Responsible Party

_____
Date

NOTE: You may be eligible for services
If you are between the ages of 50-64, please call the BCCEDP office @ 407-665-3185(Spanish) 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.) _____
_____

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

Application received by _____ Via: FAX / MAIL / Walk-in / Email Date _____

Reviewed by_____ Date_____