Libby's Legacy Breast Cancer Foundation

112 Annie St. Orlando, FL 32806
Ph (407) 898-1991 Fax (407) 431-0102
www.libbyslegacy.org

Application for Mammogram

LLBCF uses the following information to help determine eligibility. All information is kept confidential, unless otherwise stated.

Date: ______________________ Name: ____

SSN: _________-________-___________ DOB: ______/______/__________ Age: _______

Please check your status: Citizen____ Resident____ Visa____ Undocumented____

Address: ___________________________________ City: _______________ State: _____ 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?** ___________________________
How do you identify? *(Select one)* _____Lesbian _____Gay _____Bisexual___Transgender _____Heterosexual
Have you used Libby's Legacy services in the past? 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? ____Year last worked________

Do you have insurance? Y/N ________Medicaid?_______ Insurance Name/ID Number:________________________
Referring physician/clinic___________________________
Clinic address/ph ____
You MUST have a prescription for a mammogram to qualify for this service, do you? Y/N
Who is your primary Doctor? ____________________________________

Date of last mammogram: _____________Do you have your films/CDs? Y/N If No, **please call prior facility to pick up.**

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 symptom:** ____
Do you have breast 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/mo/yr?**) Partner $ _______________/ (**wk/mo/yr?**)
Other $ _____________ Food stamps$_______ (include job income, unemployment, SSI, child support, alimony, etc…)

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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) 407-665-3244 (English) to request a free mammogram. If we provide this service to you first, it can disqualify you from their program. 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: ____/____________________

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 2 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.

If I am approved for services, I understand that any appointment changes, cancellations, or reschedules must be done through Libby's Legacy or I may be billed by the service provider.

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

____
Signature of Patient / Responsible Party

____
Date

Filled out by LLBCF Staff: ___________________ Via: Phone / Walk-in Date_________________
Application received by: ____________________ Via: FAX / MAIL / Email/ Eligibilty Appt. Date:_________________
Reviewed by: _____________ Date: ___________ Scheduled on: ___________________

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