OTR: _____
RB: _____
TC: _____

APPLICATION FOR SERVICES AND INCOME DISCLOSURE

PLEASE RETURN TO: ProScan NCH Imaging, LLC, Mammogram Match Program, 1715 Medical Blvd, Naples, FL 34110, Attn: Breast Imaging Department

Please Print

Full Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Can we text you? Yes____ No_____

Email: _____ Can we email you? Yes_____ No_____

Physician Name: _____

Are you experiencing any new breast problems (e.g. lump, nipple discharge)? Yes____ No____

Are you Pregnant? Yes____ No____ Are you currently Breast Feeding? Yes____ No____

Do you have health insurance? Yes____ No____ If yes, does it cover Mammography? Yes___ No ___

Amount of Deductible: $_____ Do you have (check one): Medicare ___ Medicaid ___ Other___

Number of family members (including yourself) living at home: _____

Please fill in all pertinent income information below:

	Patient	Spouse or Dependent
Monthly Salary (gross)	$	$
Unemployment Benefits	$	$
Worker's Compensation	$	$
Social Security Benefits	$	$
Child Support	$	$
Other income (alimony, etc.)	$	$

Total Family Income Amount: Monthly $_____ Yearly: $_____

All personal financial information provided to ProScan NCH Imaging, LLC will be used solely for the purpose of determining eligibility for assistance. All information on the application and supporting materials will be kept confidential.

I hereby attest that the information provided on this application is true and correct. I authorize ProScan NCH Imaging, LLC to verify any information contained in this document for the purpose of assessing financial need and determining eligibility.

Signature: _____ Date: _____

Printed Name: _____

For PNI Purposes only: Approved _____ Not Approved _____ Date: _____

Eligibility Criteria: To be eligible for the Mammogram Match Program at the ProScan NCH Imaging, LLC Imaging Centers:

- YOU MUST BE AT OR BELOW THE INCOME GUIDELINES based on current US DHHS Poverty Guidelines (250% Poverty Level)
- YOU MUST BE UNINSURED OR UNDERINSURED (HIGH DEDUCTIBLE)
- YOU MUST BE A RESIDENT OF ONE OF THE TWO COUNTIES COVERED BY OUR PROGRAM (SEE BELOW)
- YOU MUST NOT BE RECEIVING SERVICE FOR PRE-BREAST AUGMENTATION COSTMETIC SURGERY

Covered Counties include:

FLORIDA: Collier County and Lee County

PLEASE PROVIDE THE FOLLOWING SUPPORTING DOCUMENTATION:

- Driver's license or other form of identification
- Copy of Medical Insurance Card, if applicable
- Check stubs for the past 30 days for all persons employed and living in the home
- If applicable, unemployment check stubs for the past 30 days
- Most recent IRS Tax Forms (1040 and W-2)

How did you hear about the PNI Imaging Centers? (Please check all that apply)

__ Recommended by current or former patient
__ From a friend or family member
__ Referred by a physician
__ Referred by local agency or nonprofit
__ Yellow Pages listing
__ Other (please specify:_____)
__ Advertising (please specify:_____)