



<b>Office:</b> _____ <b>Date:</b> _____ <b>Time:</b> _____ <b>OFFICE USE ONLY</b>
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## FINANCIAL ASSISTANCE REQUEST

If you prefer to fax your completed application, please fax us directly at **203-926-0417**.

**NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_  
LAST FIRST

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**SS #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **DOB:** \_\_\_\_\_ **RACE:** \_\_\_\_\_

**PHYSICIAN (REQUIRED):** \_\_\_\_\_

### ALL OF THE INFORMATION BELOW MUST BE COMPLETED

- 1) Check one of the following services:  
 Breast MRI     Mammography Screening     Diagnostic Mammography     Ultrasound
- 2) Do you have health insurance?    YES    NO
- 3) Is this service covered under your insurance?    YES    NO
- 4) What is the number of individuals living in your household? \_\_\_\_\_
- 5) What is your weekly household income? \$\_\_\_\_\_
- 6) Please describe any hardships that make it necessary to apply for financial assistance (i.e. loss of income, health insurance etc.).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of your knowledge, all information on this application is accurate and true.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>	<b>2011-2012</b>
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Approved for Financial Assistance

**Staff:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notes:**