Livingston HealthCare Foundation Mammogram Program
Enrollment and Eligibility Form

Enrollment Information

Name: _____ Other Last Name(s) Used: _____

Social Security Number: _____ Date of Birth? _____

Mailing Address: _____

City: _____ ST ____ ZIP _____ County of Residence _____

Home Phone: _____ Work Phone: _____

Email: _____ **Today's Date:** _____

Eligibility

Your current Age? _____

Do you have Medicare Part B? _____

Do you have Medicaid? _____

Family's Annual income before taxes? _____

Number of people in household? _____

Do you have insurance? _____

Insurance provider _____

What is your deductible? _____

Does it cover a mammogram? _____

Mammogram coverage Amount? _____

Medical Background

Are you having any breast problems? _____

Do you have breast implants? _____

Have you ever had a mammogram? _____ Date of last mammogram? _____

When was your last annual exam / pap smear? _____

Ethnic Background

(Check all that apply)

☐ White (non-Hispanic)
☐ Hispanic
☐ American Indian/Alaska Native
☐ Black/African American
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Unknown

How did you hear about this program?

(Check all that apply)

☐ Radio
☐ Newspaper
☐ Internet
☐ Presentation
☐ Medical Provider
☐ Family/Friend/Word of Mouth
☐ Special Event
☐ *Living Well* Newsletter
☐ Livingston HealthCare On-Hold Phone Messaging

Any other Notes/Comments for us?

_____

_____

_____

_____

_____

_____

Office Use Only

Received by: _____ Date: _____

Eligibility determination: _____ Date: _____

Patient notified: _____ Date: _____ Letter Sent: _____ Date: _____

Livingston HealthCare Foundation

Livingston HealthCare Foundation Mammogram Program

The Livingston HealthCare Foundation's Mammogram Program provides mammograms for uninsured or underinsured mammograms and breast ultrasounds, when necessary. All tests will be provided by Livingston HealthCare.

If your physician has already referred you for a diagnostic mammogram or if you have NOT had an annual exam in more than two years, you may be eligible for more comprehensive assistance through the Montana Cancer Screening Program. Please contact their office at 406-582-3107 or see online application: http://dphhs.mt.gov/Portals/85/publichealth/documents/Cancer/Eligibility%20form.pdf.

Program Guidelines

The Livingston HealthCare Mammogram Program provides mammograms for women:

- ✓ Aged 40 and older
- ✓ Under 40 with a specific request from a provider
- ✓ Who have no insurance or a high deductible
- ✓ Who live in Park County
- ✓ Residing in another county but receives care at Livingston HealthCare
- ✓ Meets the income requirements below:

Gross Yearly Income (income before taxes)	
Family Size	Total Family Income
1	$29,700
2	$40,050
3	$50,400
4	$60,750
5	$71,100
6	$81,450
7	$91,850
8	$102,250

Instructions

Please complete the Enrollment and Eligibility Form on the back of this sheet and return it to:

Livingston HealthCare Mammogram Program
320 Alpenglow Lane
Livingston, MT 59047
OR
Confidential Fax: 406-222-7606

We will review your application when received, and you should receive a letter informing you of the result of your application review. Thank you for your interest in caring for your health!