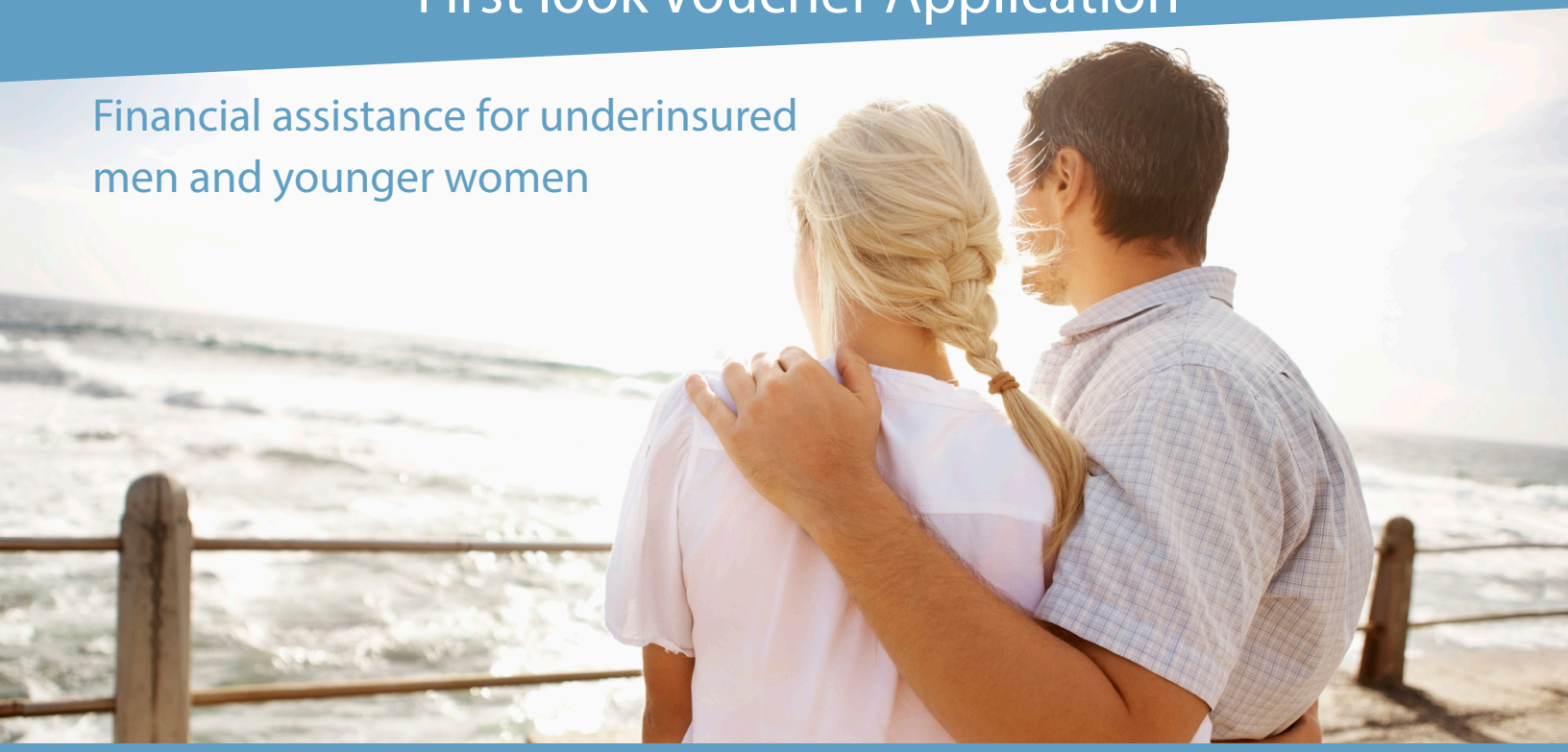
Early Detection
First look Voucher Application

Financial assistance for underinsured men and younger women



Patients must complete a First Look financial application form (see opposite side) which will determine if they are eligible for a voucher. They must also have a referral/order from an active health care provider.

Once a patient qualifies for this program, issued vouchers are good for only 45 days.

Carol Milgard
Breast Center

4525 South 19th Street
Tacoma, WA 98405
(253) 759-2622

Financial Counselor
Phone: (253) 680-3485
Fax: (253) 680-3558

First Look Voucher Program Requirements:

- A woman age 39 years or younger OR a man of any age
- Experiencing breast symptoms, requiring diagnostic breast imaging
- Underinsured or uninsured
- Low income (program will accept patients who meet up to 300% of the current Federal Poverty Guidelines)
- Must have a referring health care provider
- Must have a diagnostic referral/order from a health care provider

Please complete the application on the opposite side of this form and return it to the breast center, along with any supporting documents, at least 48 hours prior to your appointment.
You can also fax it to (253) 680-3558 or mail it to:

TRA Medical Imaging/CMBC, Attention: Financial Aid
PO Box 1535
Tacoma, WA 98401

Please contact our Early Detection Coordinator if you have any questions about this program.

First Look Voucher Program for the Carol Milgard Breast Center

Please complete this application and return it with supporting documents to our office at least 48 hours prior to your scheduled appointment.

1. Patient information

Patient name _____ Birthdate ____/____/____ MRN _____

Home phone _____ Cell phone _____

Address _____

2. Do you have health insurance? ____ YES ____ NO If you marked "NO," have you applied for insurance coverage through either private insurance or the Washington Healthplanfinder? ____ YES ____ NO Please explain why you don't have insurance. _____

_____

3. Have you been granted financial aid from any MultiCare or Virginia Mason Franciscan Health entities? ____ YES ____ NO If YES, skip to Step 7 to sign this application. In addition to the signed application, please provide a copy of the current letter of determination from the other organization in place of income documentation.

4. Spouse or parent (if applicant is a minor/dependent)

Name _____ Cell phone _____

Home phone _____ Address _____

5. Please include the last 3 months of pay stubs, W2, and other income statements along with this application.

Income (monthly totals)	Patient	Other family income
Wages		
Self-employment		
Public assistance		
Unemployment compensation		
Workers' compensation		
Alimony		
Child support		
Pension or retirement		
Interest income		
Rental property income		
Other income (detail)		
Total income		

If there was no income, please explain in detail by submitting a letter. If someone else besides a spouse or partner is providing for you, please have them write a letter stating how they help you financially. The letter must also include contact information for the person supporting you.

6. List all dependents in your household, including your spouse or partner

Name	Relationship	Age	Name	Relationship	Age

7. The above information is true and correct to the best of my knowledge. I understand that providing false or incomplete information may delay or stop my benefits. It can also cause an overpayment of benefits that I must repay and may result in penalties. I authorize Carol Milgard Breast Center to verify any of the above information and grant permission for its release to Carol Milgard Breast Center for the purpose of financial assistance eligibility determination. I swear under penalty of perjury I have given true, complete information.

_____

SIGNATURE (PERSON MAKING REQUEST) DATE

This information is confidential. Fax to (253) 680-3558 or mail to TRA Medical Imaging/CMBC, Attention: Financial Aid, PO Box 1535, Tacoma, WA 98401. For questions or assistance, please call (253) 680-3485.