



BREAST HEALTH FUND

Application Form

Patient name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

Financial & Situation Background

Amount Requested: \$ _____ Yearly income: \$ _____

Please attach a copy of the most recent W-2 form

Household income: \$ _____ Number of dependents: _____

Type of financial assistance requested: _____

Reason for request:

Have you received or explored other assistance? Yes No

Are you a previous recipient? Yes No If yes, date: _____

Amount received: \$ _____

The intent of the Breast Health Fund is to help cover the costs associated with outstanding bills relative to breast health treatment. It is open to patients all across the Upper Peninsula. Please attach copies of relevant bills.

Applications are to be submitted directly to: Marquette County Health Department, ATTN: BCCCP Coordinator.

The fund is made possible by charitable gifts made to the Superior Health Foundation.

-----office use only-----

Date received: _____ Date interviewed: _____

Committee decision: Yes No Amount awarded: \$ _____