

Livingston HealthCare Mammogram Program Eligibility and Enrollment Form

Eligibility

What is your age? _____ Do you have insurance? _____
Family's yearly income before taxes? _____ Insurance Provider _____
Number of people in household? _____ What is your deductible? _____
Do you have Medicare Part B? _____ Does it cover a mammogram? _____
Do you have Medicaid? _____ Mammogram coverage? _____

If need help understanding your insurance coverage, call 823-6414 to talk to a Patient Financial Services Representative who can help.

Enrollment Information

Social Security Number: _____ Date of Birth: _____
Name: _____ Other Last Name(s) Used: _____
Address: _____
City: _____ ST ___ ZIP _____ County of Residence _____
Home Phone: _____ Work Phone: _____
Email: _____

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)

- | | |
|---|--|
| <input type="checkbox"/> White (non-Hispanic) | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Black or African American | |

How did you hear about this program

(Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Radio | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Presentation |
| <input type="checkbox"/> <i>Living Well</i> Newsletter | <input type="checkbox"/> Medical Provider |
| <input type="checkbox"/> Livingston HealthCare On-Hold Phone Messaging | <input type="checkbox"/> Family/Friend/Word of Mouth |
| | <input type="checkbox"/> Special Event |

Additional Information: _____



LivingstonHealthCare

Livingston HealthCare Mammogram Program

The Livingston HealthCare Mammogram Program provides mammograms for uninsured or underinsured women aged 49 and under who qualify. The program includes screening and diagnostic mammograms, and breast ultrasounds, when needed. Tests will be provided by Livingston HealthCare.

If your physician has already referred you for a diagnostic mammogram, if you have not had an annual exam in more than two years, or if you are 50 or over, you may be eligible for more comprehensive assistance through the Montana Breast and Cervical Health Program. Please contact their office at 1-888-803-9343.

Program Guidelines

The Livingston HealthCare Mammogram Program provides mammograms for women:

- Aged 49 or under
- Who have no insurance or a high deductible
- Who meet the income requirements below
- Who live in Park, Sweet Grass, or Meagher Counties

Gross Yearly Income (income before taxes)	
Family Size	Total Family Income
1	\$27,225
2	\$36,775
3	\$46,325
4	\$55,875
5	\$65,425
6	\$74,975
7	\$84,525
8	\$94,075

Instructions

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

Livingston HealthCare Mammogram Program

1001 River Drive
Livingston, MT 59047

Confidential Fax: 406-222-7606

We will notify you once we have reviewed your application. If you are eligible, you will receive a voucher in the mail for your mammogram. Present your voucher to hospital admissions when you arrive for your mammogram appointment.

Official Use Only

Form received by: _____ Date: _____

Eligibility determination: _____ Date: _____

Patient notified: _____ Date: _____ Voucher Sent: _____ Date: _____