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: ______________________________

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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: $ ______________