



Public Health
Delta & Menominee Counties

**Breast Services Funding Project
Application Form**

Applicant's Name: _____

County of residence: _____

Address: _____

City: _____ **State:** Michigan **Zip:** _____

Phone: _____ **Email:** _____

Yearly Household Income: _____

Number of People Supported by This Income: _____

Insurance: _____ **Deductible:** _____

Reason for Request: _____

Breast Services Anticipated: _____ **When:** _____

Last Screening Mammogram: _____

Mailing address:

Public Health, Delta & Menominee Counties
Attention: Kristi Steger, RN
2920 College Avenue
Escanaba, MI 49829

For more information contact:

Kristi Steger
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ksteger@phdm.org