BOSOM BUDDIES
Breast Cancer Support Group of Southwestern Colorado, Inc.

Breast Cancer Support Group of Southwestern Colorado, Inc. Financial Support Application
This service is available to residents of Montrose, San Miguel and Ouray Counties

Name: _____Age: _____Date of Birth_____

Address:_____

Phone:_____Email:_____ Referred by: _____

Send to:
Bosom Buddies c/o Denise Weaver, P.O. Box 906, Telluride, CO 81435
Questions: Denise Weaver at 970-209-2118; Jenny Sullivan at 970-728-4104

FINANCIAL INFORMATION

My household consists of _____ adults and _____ children.
My household income was $_____ for the last calendar year.
My estimated household income for this calendar year is $_____.
I am attaching the following financial documents:

( ) Copy of most recent income tax return.
( ) Employer verification of my earnings this year.
( ) Other

MEDICAL INFORMATION

I am requesting financial assistance for:

( ) Mammogram or Breast MRI
( ) Ultrasound or Biopsy Services
( ) Radiologist Services
( ) Prosthesis (Maximum $200.00)
( ) Other diagnostic procedure or support services _____

Any further procedures after prescribed biopsy are subject to approval

INSURANCE INFORMATION

( ) My medical insurance company is _____.
The expenses which will be covered by my insurance, are: _____.
( ) I do not have medical insurance coverage.
( ) I do not have Medicare/Medicaid coverage.
( ) This is follow up care (application on file).

SIGNING THIS APPLICATION WILL GIVE BOSOM BUDDIES PERMISSION TO ACCESS YOUR HOSPITAL RECORDS FOR PROCEDURES FOR WHICH YOU ARE REQUESTING ASSISTANCE.

_____ Applicant Signature Date_____ (required)

(Check One) Submitted by Applicant _____or Provider_____