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 491, Norwood CO 81423 (email denise@smartbynature.com)
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_____