Dear Potential Client,

Thank you for contacting the Bridge Breast Network to receive assistance with your breast health issue. Please review the enclosed copy of our Financial Assistance then sign, date and have someone to witness your signature. ***Please return the application and supporting documents by fax: 214-821-0869, U.S. Mail, or in person during our Intake hours on Tuesday and Thursday at 10:00 a.m. in our office at 4000 Junius Street, Dallas, TX 75246 (Baylor Medical Center Dallas).*** **Please do not delay in returning all requested information. The Bridge Breast Network will not be able to assist you until all information is received. Please submit the following item(s):**

1. Intake Form: you must complete, sign and date if requesting diagnostic or treatment services

2. Consent Agreement: Signed and dated by you and a witness (anyone over the age of 18 years) must both

3. Release of Protected Health Information: complete, sign and date

4. Copy of current driver's license or government issued ID (if address on ID is not current, you must also include copy of a current utility bill)

5. Twenty dollars ($20) non-refundable processing fee is due with your application. **Processing fee may be paid by check, cash or credit/debit card ($23.00 if paying by credit/debit card payments).**

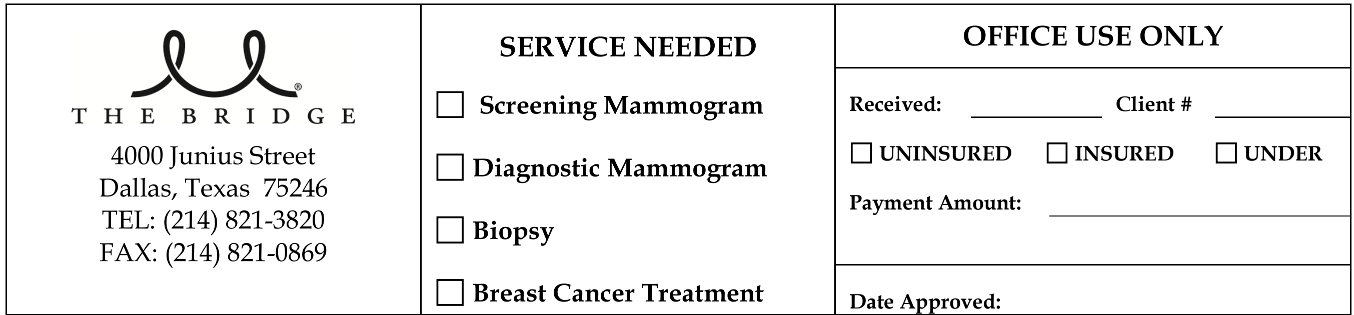
6. Provide Proof of Income **(submit a copy of one of the following):**
   - Last two paycheck stubs (If married, we need check stubs from you and your spouse)
   - Self-Employed: Previous year IRS 1040 Tax Return (including ALL Schedules)
   - Supporter Statement (If you are supported by someone other than your spouse)-**THIS FORM MUST BE SIGNED AND NOTARIZED**
   - Unemployment Verification (If receiving unemployment payments)
   - Workman's Comp Verification (If receiving Workers Compensation payments)
   - Other (Other proof of income as applicable)
   - Employer Verification: if you are paid by cash or personal check

7. Employer Verification Form: Health Insurance Section (if you or your spouse is employed)

8. Copy of mammogram report or physician referral (if applicable)

**Please do not delay in returning all requested information. The Bridge Breast Network will not be able to assist you until all information is received.** Do not hesitate to contact me at 214-821-3820 or toll free 1-877-258-1396 should have any questions.

Sincerely,
Case Management Staff



| THE BRIDGE<br>4000 Junius Street<br>Dallas, Texas 75246<br>TEL: (214) 821-3820<br>FAX: (214) 821-0869 | **SERVICE NEEDED**<br>☐ Screening Mammogram<br>☐ Diagnostic Mammogram<br>☐ Biopsy<br>☐ Breast Cancer Treatment | **OFFICE USE ONLY**<br>Received: ________ Client # ________<br>☐ UNINSURED ☐ INSURED ☐ UNDER<br>Payment Amount: ________<br>Date Approved: |
|---|---|---|

**CLIENT INFORMATION** **Referred by** ____________________

☐ Non-English Speaking- what language? ____________________

Last name ____________ First name ____________ MI ______

Gender ☐ M ☐ F Date of Birth ____________ SS# / Tax ID ____________

Citizenship Status: ☐ U.S. Born ☐ Naturalized Citizen ☐ Visiting Visa ☐ Resident Alien ☐ Undocumented

Ethnicity/Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Middle Eastern ☐ Other (please specify)

Address ____________________

City ____________ State TX Zip ________ County ____________

Home # ____________ Work # ( ) - ________ Emergency # ____________

Cell # ____________ Email: ____________________

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Common Law

Total Family Size ________ Ages of Children (list your children that are 18 & under or who are full-time students) ____________

**MEDICAL INFORMATION** - check all that applies

☐ Primary Care Physician Name ____________ Phone# ____________

☐ Last Mammogram Date / / Imaging Center Name ____________

☐ Personal/Family History of Cancer. If yes, who? ____________

**Do you have any of the following?**

| | | | |
|---|---|---|---|
| Breast Implants? | ☐ Y ☐ N | Change in appearance or inversion of nipple? | ☐ Y ☐ N |
| Change in shape or firmness? | ☐ Y ☐ N | Nipple Discharge? | |
| Enlarged Breast Lump? | | • Discharge appears while squeezing | ☐ Y ☐ N |
| • Left Breast | ☐ Y ☐ N | • Discharge is spontaneous | ☐ Y ☐ N |
| • Right Breast | ☐ Y ☐ N | • Is discharge bloody in color | ☐ Y ☐ N |
| Silicone Injections | ☐ Y ☐ N | • Is discharge clear | ☐ Y ☐ N |
| Dimpling or creasing in breast skin? | ☐ Y ☐ N | • Is discharge greenish | ☐ Y ☐ N |
| Lumps in the underarm? | ☐ Y ☐ N | • Does discharge have a smell /odor | ☐ Y ☐ N |
| Breast skin is red or orange color? | ☐ Y ☐ N | Breast feels warm /hot when touched? | ☐ Y ☐ N |

**STOP HERE IF SCREENING MAMMOGRAM ONLY IS NEEDED**

***THIS SECTION MUST BE COMPLETED FOR DIAGNOSTIC AND/OR TREATMENT SERVICES***

## FINANCIAL INFORMATION

| Employment Status | Client | Spouse |
|---|---|---|
| • Unemployed | ☐ Y ☐ N | ☐ Y ☐ N |
| • Disabled | ☐ Y ☐ N | ☐ Y ☐ N |
| • Employed | ☐ Y ☐ N | ☐ Y ☐ N |
| • Retired | ☐ Y ☐ N | ☐ Y ☐ N |
| • Self-Employed (submit Form 1040 and all Schedules) | ☐ Y ☐ N | ☐ Y ☐ N |
| • Student | ☐ Y ☐ N | ☐ Y ☐ N |

**Monthly Income Amounts**

☐ Supporter Statement

Food Stamps ☐ Y ☐ N

| | | | |
|---|---|---|---|
| Gross Wages | $ ________ | VA Benefits | $ ________ |
| Soc. Security | $ ________ | Housing Auth. | $ ________ |
| AFDC/TANF | $ ________ | Workers Comp. | $ ________ |
| SSI/ Disability | $ ________ | Pension | $ ________ |
| Unemployment | $ ________ | Other: | $ ________ |
| Child Support | $ ________ | | |

**OFFICE USE ONLY**

**Total Monthly** $ ________

Asst Level: ☐ 0 ☐ 1 ☐ 2 ☐ Over

## INSURANCE INFORMATION

Do you current have access to or insurance that pays for all or part of your medical bills? ☐ Yes ☐ No

If yes, check all that apply:

- ☐ Medicaid: ☐ Traditional ☐ Texas Women's Medicaid
- ☐ Medicare: ☐ Part A ☐ Part B
- ☐ Private Insurance: Insurance Provider Name ______________________________
- ☐ Texas Risk Pool
- ☐ Parkland Plus
- ☐ JPS Connect
- ☐ County Indigent Program
- ☐ Cancer Policy
- ☐ Other (specify) __________________________

I agree that if my insurance situation changes, I will contact the Bridge Breast Network. Failure to contact the Bridge upon receiving benefits will result in paying back the Bridge for services rendered while insured. In addition you will be dismissed as a Bridge client.

**CERTIFICATION OF INFORMATION:** I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under Federal law, State law, or both and will be subject to immediate termination of services. I certify under penalty of perjury that the information provided on this application is true and complete to the best of my knowledge. If it is not, I will be subject to termination of services, repayment fees paid for by the Bridge Breast Network for my services received, and/or criminal prosecution. Your signature below authorizes use of the above information by the Bridge Breast Network to determine eligibility for services. This information will be kept in the strictest confidence and will only be used for program purposes.

______________________________ ______________________________

Signature **(parent/guardian if applicants under 18)** **Date**

## *Financial Assistance Policy & Release of Liability*

**Background Information**

The Bridge Breast Network (BBN) is a non-profit organization funding diagnostic and treatment services for breast cancer to medically underserved women and men. Individuals must qualify for Bridge services by completing an intake form and meeting eligibility criteria.

**Financial Assistance Policy**

***The BBN assumes no financial responsibility for any medical procedure unless the Case Manager has approved the procedure with the client.***

The BBN offers limited financial assistance to clients for diagnosis and treatment for breast cancer only. The Bridge assumes responsibility for follow-up care for the diagnosis. Every 6 months, the client will be asked to update all intake information. A change in this information may disqualify a client for further services. If there is a reoccurrence of breast cancer, the client must requalify for assistance. Failure to provide the information will be reason for being dismissed as a Bridge client.

The BBN will refer clients to appropriate physicians and/or medical facilities in our network for diagnosis and treatment.

***The BBN does not assume responsibility for diagnosis and treatment of metastatic breast cancer (breast cancer that has spread to other organs of the body). The BBN does not treat Fibroadenomas and/or other non-cancerous breast conditions unless specifically recommended by a physician to rule out a final cancer diagnosis.***

**Release of Liability**

*Waiver of Claims:* The Bridge Breast Network is a 501c(3) non-profit corporation. Medical professionals donate their time on a voluntary basis. The services being provided might not be available but for the efforts of the BBN volunteers. The individuals provided services are not obligated to do so, but are doing so on a voluntary basis. The fair market of the services the client will receive far exceeds the amount she/he will be expected to pay.

***The BBN has the right, in its sole discretion, to refuse to provide service or withdraw service in the event it determines that misrepresentation regarding information on the client's intake form have been made. In addition, the BBN may refuse or withdraw assistance for any other reason.***

## CLIENTS REQUIRING BREAST CANCER TREATMENT SERVICES

- **Copy of most recent IRS Income Tax Return must be submitted.**
- **The client is required to pay a portion of the cost for treatment services in the amount of $500 for each phase of treatment received through the BBN. Payment must be received by the BBN before phase of treatment is rendered. Fees may be paid by check, cash, money order or credit/debit card ($525.00 if paying by credit/debit card). Surgery: $500 / Chemotherapy: $500 / Radiation: $500.**

# *Consent Agreement*

I, _________________________________, fully understand the conditions of the Bridge Breast Network's Financial Policy and Release of Liability.

I understand that by signing this form I am giving up my right to assert any claim or demand for damages of any type arising out of the services provided to me through the effort and assistance of the Bridge Breast Network. In consideration for being permitted to receive the services provided, by signing below, I do forever release, hold harmless and discharge the Bridge Breast Network, its officers, directors, agents, volunteers, sponsors, employees, successors and assigns from any and all claims, causes of action, damages, demands or liability arising out of or connected in any manner arising out of my receipt of services.

By signing below, I acknowledge and agree that the Bridge's agreement to offer limited assistance for diagnosis and treatment of breast cancer does not obligate the Bridge to provide assistance for diagnosis and treatment for metastatic disease or any other related condition or illness.

**By signing below, I acknowledge and agree that the Bridge has the right, in its sole discretion, to refuse to provide or withdraw assistance in the event it determines that misrepresentations regarding my intake information have been made. In addition, failure to comply with updating financial and demographic data when requested can result in being dismissed as a Bridge client.**

I have carefully reviewed this agreement and am signing it of my own free will and not under duress or coercion of any kind. I am competent to sign this waver.

This release is made and intended to bind me as well as my heirs, executors, administrators, and assigns. This agreement is made in Texas and is intended to be construed under Texas law.

_______________________________________________________ (Client's name printed)

_____________________________________ (Client's signature*) ______________ Date

_______________________________________________________ (Witness's name printed)

_____________________________________ (Witness's signature) ______________ Date

*Signature **(parent or guardian for applicants under 18)**

Rev. (09/2014)

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**Release for Medical Records and Imaging Studies:**

From: ______________________________

______________________________

To: ______________________________

______________________________

FOR OFFICE USE ONLY

Client Name *(type or print)*: ______________________________

SSN: ____________________ Date of Birth: ____________________

When you obtain services from any Bridge Breast Network provider, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. You may request a copy of the Bridge Privacy Policy and Practices at any time. You have the right to request that we restrict how protected health information about you is used.

I understand no information pertaining to my medical visits will be disclosed to anyone for purposes outside of normal treatment, payment, and program operations. I understand that I will be responsible for informing those people that I wish to be aware of reasons for my medical visits. Further, I understand the Bridge and its providers are not responsible for any disclosures regarding my medical condition and/or treatments that are made by people that I inform.

I also understand this restriction will have no impact on The Bridge right to disclose and use my protected health information for purposes of treatment, payment and health care operations.

I authorize The Bridge to discuss my medical history, diagnosis and treatment with the following persons:

| Relationship | Name | Phone Number |
|---|---|---|
| ☐ Spouse | | |
| ☐ Children | | |
| ☐ Parent(s) | | |
| ☐ Other (specify) ____________ | | |

This authorization will expire at the end of 12 months, unless I revoke the consent prior to that time.

Client Signature: ______________________________ Date: ____________

**(Parent or guardian for applicants under 18)**

Rev. (09/2014)

| | **EMPLOYER VERIFICATION FORM** |
|---|---|

**SECTION I. Health Insurance: Please verify whether employee and/or family members are covered under your current group health insurance plan.**

| 1. Does company offer insurance? | Y ☐ N ☐ |
|---|---|
| 2. If yes, is the client listed below covered? | Y ☐ N ☐ If yes, complete section below |

- If yes to Question #2, does the insurance plan cover breast health issues? Y ☐ N ☐
- If yes, what services are covered? ☐ Mammogram ☐Biopsy ☐ Breast Surgery ☐ Breast Cancer Treatment
- Please provide policy page related to coverage.

**SECTION II. Employment Verification**

I, ______________________________ verify that ______________________________
Employer Representative Employee's full name

is employed at ______________________________ as a ______________________________
Name of Employer Position/Title

**Earnings:**

❑ Employee earns $____________ every ☐Week ☐Two Weeks ☐Semi-Monthly ☐Month

List last four payments:

Dates: ____________ Amounts: ____________
____________ ____________
____________ ____________
____________ ____________

Employed since: ____________________
Date Hired

**SECTION III. Additional Assistance:**

**I provide the following: ☐ Food ☐ Room/Board ☐ Personal items ☐ Transportation ☐ Other ________________**

**I certify that the above information is true and correct. "I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under Federal law, State law, or both and will result in termination of services. Everything on this application is the truth as best I know it."**

______________________________ ______________________________
**Signature of Employer Representative** **Date**

______________________________ ______________________________
**Printed Name** **Title**

______________________________ ______________________________
**Business/Company Name** **Phone Number**

**Your prompt attention to this request is appreciated. Please fax this information to:**
**The Bridge Breast Network - Attn: Intake**
**Fax: (214) 821-0869**

**Client Name:** ______________________________ **ID#:** ____________________