

Kim Rowden Memorial Fund Mammogram Grant Application

The Kim Rowden Memorial Fund (herein, “we”) realize that the costs of healthcare may (1) prevent you or a member of your family from receiving screening or diagnostic care, and/or (2) cause a significant financial burden on you and/or your family if you or a member of your family has received or is in need of screening and other diagnostic procedures. In both cases, the financial burden inhibits a healthy lifestyle.

In an effort to assist you with these burdens, we offer financial assistance to certain qualified applicants. To be eligible for assistance, we require you to complete this application process, which we review based on a number of factors, including but not limited to: financial need, medical care received, overall impact of grant, and cost of proposed procedure. To assist in our review, please answer the following questions. We may request additional information to assist in our review, if needed.

KIM ROWDEN MEMORIAL FUND MAMMOGRAM GRANT APPLICATION		
APPLICANT INFORMATION		
Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Married Widowed Single Divorced (Please circle)		
Own Rent (Please circle)	Monthly payment or rent:	How long?
APPLICANT EMPLOYMENT INFORMATION		
Current employer:		
Position:	Hourly Salary (Please circle)	Annual income:
APPLICANT'S SPOUSE INFORMATION, IF MARRIED		
Name:		
Date of birth:	SSN:	Phone:
APPLICANT'S SPOUSE EMPLOYMENT INFORMATION		
Current employer:		
Position:	Hourly Salary (Please circle)	Annual income:
FINANCIAL INFORMATION		
Total Net Monthly Income:		
HEALTHCARE INSURANCE		
Do you currently have healthcare insurance?		
Have you applied for TennCare (or equivalent in other states)?	Which TennCare policy do you have?	If Denied, Reason for denial:
HEALTHCARE PROVIDER TO BE PAID		
Provider Name:		
Provider address:		
City:	State:	ZIP Code:
Tests performed: MAMMOGRAM	Billing Contact:	Phone:
AUTHORIZATION		
I do not currently have healthcare insurance or the financial means to pay for screening and diagnostic tests. <u>UNDER PENALTY OF LAW, I HEREBY CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT.</u>		
Signature of applicant		Date
Application taken by		Date