Never Surrender:

Application for Mammogram Voucher Program

To apply for financial assistance from Never Surrender, please follow these steps:

1. Call “**First Call for Help”** at **211** for a screening appointment.
2. Take all of the following (that apply to you) to your appointment.
	1. Picture ID of some kind
	2. Proof of income
	3. Statement of all monthly expenses
	4. Food stamp information (if applicable)
	5. Social Security Number
3. **Allow at least 3 weeks for application processing. The process can be up to 6 months wait depending on availability of funds.**

|  |  |
| --- | --- |
| Name (Last, First, Middle): | DOB:      |
| Mailing Address:       | City, State & Zip:       | Date of last mammogram: |
| Social Security Number:      | Home Phone:       | Work Phone:      | Other Phone:       |
| Place of Employment: |  |
| Spouse & Employer: | DOB: |
| Dependant: | DOB: |
| Dependant: | DOB: |
| Dependant: | DOB: |
| Dependant: | DOB: |
| Do you have medical insurance coverage? [ ]  Yes [ ]  NoIf yes, please provide insurance information (type of insurance, policy and group #, effective date, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**IMPORTANT: READ CAREFULLY – AUTHORITY TO OPERATE, RELEASE RECORDS, USE PICTURES, AND DENY SERVICES**

 It is required that this form be signed by each applicant, or by the parents or legal guardian, if applicant is not of legal age in accordance with the laws of the State of Alabama. This signed document certifies that the undersigned consents to the administration of services, and requirements set forth by Never Surrender, or in the opinion of doctors or medical residents cooperating with Never Surrender be necessary or advisable. The undersigned agrees to the use of pictures for promotional purposes if such use will aid never Surrender in the promotion of association functions.

Never Surrender and cooperating mammography facilities are hereby resolved of any responsibility in connection with treatment, prescribed pharmaceuticals, surgery, or hospitalization. They are also authorized to release information and records when necessary for consultation with physicians, clinic personnel, officers of the court, or other special emergency use of hospital personnel.

I understand that Never Surrender has the legal right to deny a service if any of the above information is found untrue. I also understand that I will be responsible for any expenses incurred if services are denied for the above reason.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please attach a letter (2-3) paragraphs on why you are requesting a mammogram voucher.***

*Before returning to Never Surrender, make sure all information is answered by the best of your knowledge. All applications are considered and reviewed nonbiased.*

**You do not have to contact Never Surrender concerning your application, we will contact you.**

Never Surrender:

Application for Mammogram Voucher Program

##  Income and Expense Verification \*\*\*This area must be filled out by referring agency ONLY!!\*\*\*

 Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Examiner’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Income Sources: | Amount: |
|  |       |
|  |       |
|  |       |
|  |       |
|  |       |
|  |       |

|  |  |
| --- | --- |
| Expenses: | Amount: |
| Power |       |
| Gas |       |
| Water |       |
| Car(s) |       |
| Automobile Insurance |       |
| Gas for Automobile |       |
| Rent |  |
| Cable |  |
| Phone |  |
| Cell Phone |  |
| Medical Bills |  |
| Food |  |
| Credit Cards |  |
| Other |  |
| Total: |  |

 Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - Expenses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ = TOTAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examiners Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you recommend this applicant for assistance: Yes No

 **FOR ANALYSIS BY COMMITTEE**

|  |  |  |
| --- | --- | --- |
| Date Reviewed:  | [ ]  Approved [ ]  Denied | % Approved: |
| Valid Until:  | Initials: |