



Newman Regional Health Foundation
1201 West 12th Avenue
Emporia KS 66801
620-343-6800 extension 1921

**FINANCIAL ASSISTANCE FOR SCREENING MAMMOGRAPHY
APPLICATION**

NAME _____
FIRST NAME MIDDLE INITIAL LAST NAME

ADDRESS _____
CITY STATE ZIP COUNTY

TELEPHONE # _____ BIRTHDAY _____

PLEASE INITIAL CRITERIA BELOW AS ACKNOWLEDGEMENT:

- _____ I do not have insurance coverage
- _____ I am not eligible for Early Detection Works (EDW) grant funds
- _____ I don't have any other financial assistance available
- _____ I agree that funds will only be used for screening mammograms
- _____ I understand that diagnostic procedures funds are not available
- _____ I do not have the financial ability to pay for the service
- _____ I understand that services must be provided at the W.S. & E.C. Jones Breast Care Center at Newman Regional Health

By signing below I attest that the above information is accurate. If another source of payment is identified this application will become null and void.

Applicant Signature

Date

Return by mail to: Newman Regional Health Foundation, 1201 W. 12th Ave., Emporia, KS 66801

Foundation Approval

Date