Breast MRI Program

Dear Valued Patient:

Thank you for taking charge of your breast health and showing interest in the Cris Collinsworth ProScan Fund's Pink Ribbon Breast MRI Program which provides funding for Breast MRI for patients who qualify.

It is important that patients understand their level of breast density. If you are a dense breasted patient, your physician may recommend a breast MRI which increases detection of breast cancer in dense breasted patients. Studies have shown that Breast MRI is more sensitive than mammography at detecting nearly all invasive cancers and a majority of noninvasive cancers especially in dense breasted patients. Detecting a cancer in dense breast tissue is more difficult than detecting it in fatty tissue.

Breast MRI should not replace a mammogram, but should be a screening tool in conjunction with mammogram for patients whose mammograms may be difficult to read due to the level of breast density.

Currently insurance companies are not yet covering this procedure for all of the patients it could benefit. The Cris Collinsworth ProScan Fund believes the evidence which shows the increased detection rate is reason to fund this program and therefore will provide funding for patients who have an annual family income at or below 400% of the Federal Poverty Guidelines.

Should you qualify for the program, we will provide you with a list of participating imaging centers and hospitals locally. We will send you their information for scheduling an appointment. At most providers, the breast MRI program will cover the scan in full. If you choose a provider who has a higher cost than what this program will cover, you will be responsible for the cost exceeding the $400 that the Cris Collinsworth ProScan has agreed to pay towards the service. The prices will be provided by the Cris Collinsworth ProScan Fund when you are making your decision.

Please fill out the application, sign it, and fax, email or mail it back to our office at the address listed at the top of the application. Once we have received the completed application, we will review and contact you. You are also eligible to receive complimentary transportation to and from your appointment. Please contact Maggie Fennell at 513-924-5038 if you would like to schedule transportation. Please understand the information you provide on the application will be kept private and used only to process your application.

Thanks again for taking charge of your breast health!

The Cris Collinsworth ProScan Fund
513-924-5038 (office)

Breast MRI Program

APPLICATION FOR SERVICES AND INCOME DISCLOSURE

PLEASE MAIL TO: Breast MRI Program 5400 Kennedy Avenue, Cincinnati, OH 45213 OR FAX to 513-352-9370

Full Name: _____

Marital Status: Single ____ Married ____ Ethnicity: _____ Religion: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (Home)_____ (Work)_____ Age: _____ Birth Date: _____

Physician's Name: _____

Did your mammogram report state that you are dense breasts? Yes_____ No_____

Was a breast MRI recommended on your mammogram report? Yes_____ No_____

Have you had or ever been recommended to have a breast biopsy? Yes_____ No_____

Do you have a first degree relative diagnosed with breast cancer (mother, father, sister, brother, aunt, uncle, grandmother, grandfather, daughter, son)? Yes_____ No_____ Relation: _____

Do you have any type of health insurance? Yes_____ No_____ Employer _____

Do you have (check one): __Medicare __Medicaid __Other Amount of Deductible: _____

Number of family members (including yourself) living at home: _____

Please fill in all pertinent income information below:

	Patient	Spouse	Working Children
Monthly Salary (gross)	$	$	$
Public Assistance Benefits	$	$	$
Unemployment Benefits	$	$	$
Social Security Benefits	$	$	$
Worker's Compensation	$	$	$
Child Support	$	$	$
Other income (alimony, etc.)	$	$	$

Total Family Income Amount: Monthly $_____ Yearly: $_____

All personal financial information provided to the Cris Collinsworth ProScan Fund will be used solely for the purpose of determining eligibility for assistance. All information on the application and supporting materials will be kept confidential. I hereby attest that the information provided on this application is true and correct. I authorize the Cris Collinsworth ProScan Fund to verify any information contained in this document for the purpose of assessing financial need and determining eligibility. I authorize the provider to provide a copy of my results to the Cris Collinsworth ProScan Fund to analyze the program's effectiveness.

Signature_____ Date_____

Printed Name _____ ___ Approved ___ Not Approved

Signature, Authorizing Official: _____ Date: _____

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Eligibility Criteria: To be eligible for services at no cost at the ProScan Pink Ribbon Centers:

- YOU MUST BE AT OR BELOW 400% of the FEDERAL POVERTY GUIDELINES based on current US DHHS Poverty Guidelines. Add $16,640 for each additional person in the household.
  - 1 person = $47,080
  - 2 persons = $63,720
  - 3 persons = $80,360
  - 4 persons - $97,000
- YOU MUST BE A RESIDENT OF THE 13 COUNTIES COVERED BY OUR PROGRAM (SEE BELOW)
- YOUR MOST RECENT MAMMOGRAM REPORT MUST STATE THAT YOU HAVE "DENSE BREASTS" AND THE REPORT MUST RECOMMEND A BREAST MRI
- BREAST MRI IS NOT COVERED BY INSURANCE

Covered Counties include:

OHIO:	BROWN, BUTLER, CLERMONT, HAMILTON, HIGHLAND, MONTGOMERY, PREBLE, WARREN
KENTUCKY:	BOONE, CAMPBELL, KENTON
INDIANA:	DEARBORN, FRANKLIN

PLEASE PROVIDE THE FOLLOWING SUPPORTING DOCUMENTATION:

- Driver's license or other form of identification
- Copy of Medical Insurance Card, if applicable
- Check stubs for the past 30 days for all persons employed and living in the home
- If applicable, unemployment check stubs for the past 30 days
- Most recent IRS Tax Forms (1040 and W-2)

How did you hear about the Pink Ribbon Center? (Please check all that apply)

__ Recommended by current or former patient
__ Referred by local agency or nonprofit
__ From a friend or family member
__ Yellow Pages listing
__ Referred by a physician
__ Other (please specify :_____)
__ Advertising (please specify :_____)