



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 have dense breasts, 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 detect cancer due to the level of breast density.

Currently insurance companies are not yet covering this procedure for all patients that 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 Breast MRI for patients with dense breasts and 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 and help you schedule. A prescription from a physician is required.

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 it and contact you. You are also eligible to receive complimentary transportation to and from your appointment. Please contact the ProScan Pink Ribbon Center at 513-527-7750 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.

Sincerely,

The Cris Collinsworth ProScan Fund
Pink Ribbon Programs

Cris Collinsworth ProScan Fund
5400 Kennedy Avenue | Cincinnati | Ohio | 45213
ccpf.org | 513-527-7750 | pinkribbon@proscan.com



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

How did you hear about the Breast MRI Program? _____

Full Name: _____

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

Address: _____

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

Phone: _____ Email _____ Birth Date: _____

Physician's Name: _____ Date of last mammogram: ___/___/___ Location: _____

Did your mammogram report state you have 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 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 radiology results to the Cris Collinsworth ProScan Fund to analyze the program's effectiveness. CCPF may contact me by email address or phone number provided above regarding the program.

Signature _____ Date _____

Printed Name _____

For CCPF Purposes Only: Approved _____ Not Approved _____ Date: _____



Breast MRI Program

Eligibility Criteria: To be eligible for services at no cost at the ProScan Pink Ribbon Centers all of the following must be applicable:

- YOU MUST BE AT OR BELOW 400% of the FEDERAL POVERTY GUIDELINES based on current US DHHS Poverty Guidelines. Add \$5,140 for each additional person over 8.
 - 1 person = \$58,320
 - 2 persons = \$78,880
 - 3 persons = \$99,440
 - 4 persons - \$120,000
- YOU MUST BE A RESIDENT OF ONE 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
- YOUR BREAST MRI IS NOT COVERED BY INSURANCE

***A prescription from a Physician is required**

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
- 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 CCPF Breast MRI Program? (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 : _____)