Dear Potential Client,

Thank you for contacting the Bridge Breast Network to receive assistance with your breast health issue. Please review the enclosed copy of our Financial Assistance then sign, date and have someone to witness your signature. ***Please return the application and supporting documents by fax: 214-821-0869, U.S. Mail, or in person during our Intake hours on Tuesday and Thursday at 10:00 a.m. in our office at 4000 Junius Street, Dallas, TX 75246 (Baylor Medical Center Dallas).*** **Please do not delay in returning all requested information. The Bridge Breast Network will not be able to assist you until all information is received. Please submit the following item(s):**

1. Intake Form: you must complete, sign and date if requesting diagnostic or treatment services

2. Review and initial Financial Assistance Policy page

3. Consent Agreement: Signed and dated by you and a witness (anyone over the age of 18 years)

4. Release of Protected Health Information: complete bottom section, sign and date

5. Copy of current driver's license or government issued ID (if address on ID is not current, you must also include copy of a current utility bill)

6. Twenty dollars ($20) non-refundable processing fee is due with your application. **Processing fee may be paid by check, cash or credit/debit card ($23.00 if paying by credit/debit card payments).**

7. Provide Proof of Income **(submit a copy of one of the following):**
   - Last paycheck stub (If married, we need check stubs from you and your spouse)
   - Self-Employed: Previous year IRS 1040 Tax Return (including ALL Schedules)
   - Supporter Statement and Their Tax Return (If you are supported by someone other than your spouse)-**THIS FORM MUST BE SIGNED AND NOTARIZED AND INCLUDE A COPY OF THE PERSON PROVIDING SUPPORT TAX RETURN**
   - Unemployment Verification (If receiving unemployment payments)
   - Workman's Comp Verification (If receiving Workers Compensation payments)
   - Other (Other proof of income as applicable)
   - Employer Verification Form: if you are paid by cash or personal check or have no check stubs

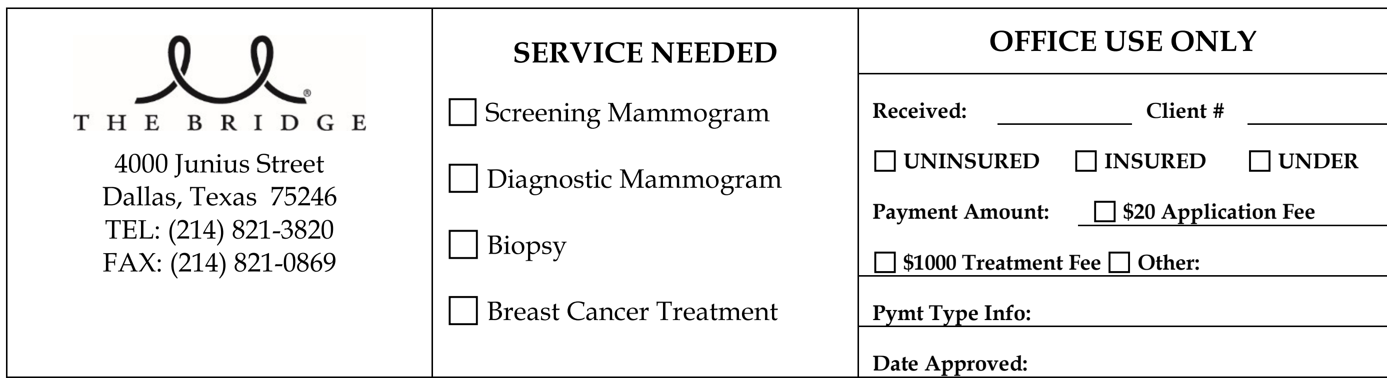
8. Copy of physician referral or Order for services (if applicable)

9. Sign Acknowledgement of Privacy Practices Notice

Please do not delay in returning all requested information. The Bridge Breast Network will not be able to assist you until all information is received. Do not hesitate to contact me at 214-821-3820 or toll free 1-877-258-1396 should have any questions.

Sincerely,
Case Management Staff

Rev. (10/2016)



THE BRIDGE

4000 Junius Street
Dallas, Texas 75246
TEL: (214) 821-3820
FAX: (214) 821-0869

SERVICE NEEDED

☐ Screening Mammogram

☐ Diagnostic Mammogram

☐ Biopsy

☐ Breast Cancer Treatment

OFFICE USE ONLY

Received: ________ **Client #** ________

☐ **UNINSURED** ☐ **INSURED** ☐ **UNDER**

Payment Amount: ☐ **$20 Application Fee**

☐ **$1000 Treatment Fee** ☐ **Other:**

Pymt Type Info:

Date Approved:

CLIENT INFORMATION **Referred by** ____________________

☐ Non-English Speaking- what language? ____________________

Last name ____________ First name ____________ MI ________

Gender ☐ M ☐ F Date of Birth ____________ SS# / Tax ID ____________

Citizenship Status: ☐ U.S. Born ☐ Naturalized Citizen ☐ Visiting Visa ☐ Resident Alien ☐ Undocumented

Ethnicity/Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Middle Eastern
☐ Other (please specify)

Address ____________________

City ____________ State TX Zip ________ County ____________

Home # ____________ Work # ( ) - ____________ Emergency # ____________

Cell # ____________ Email: ____________________

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Common Law

Total Family Size ________ Ages of Children 18 & under ____________

MEDICAL INFORMATION - check all that applies

☐ Primary Care Physician Name ____________ Phone# ____________

☐ Last Mammogram Date / / Imaging Center Name ____________

☐ Personal/Family History of Cancer. If yes, who? ____________

Do you have any of the following?

Breast Implants?	☐ Y ☐ N
Change in shape or firmness?	☐ Y ☐ N
Enlarged Breast Lump?	
• Left Breast	☐ Y ☐ N
• Right Breast	☐ Y ☐ N
Silicone Injections	☐ Y ☐ N
Dimpling or creasing in breast skin?	☐ Y ☐ N
Lumps in the underarm?	☐ Y ☐ N
Breast skin is red or orange color?	☐ Y ☐ N
Change in appearance or inversion of nipple?	☐ Y ☐ N
Nipple Discharge?	
• Discharge appears while squeezing	☐ Y ☐ N
• Discharge is spontaneous	☐ Y ☐ N
• Is discharge bloody in color	☐ Y ☐ N
• Is discharge clear	☐ Y ☐ N
• Is discharge greenish	☐ Y ☐ N
• Does discharge have a smell /odor	☐ Y ☐ N
Breast feels warm /hot when touched?	☐ Y ☐ N

STOP HERE IF SCREENING MAMMOGRAM ONLY IS NEEDED

THIS SECTION MUST BE COMPLETED FOR DIAGNOSTIC AND/OR TREATMENT SERVICES

FINANCIAL INFORMATION		
Employment Status	**Client**	**Spouse**
• Unemployed	☐ Y ☐ N	☐ Y ☐ N
• Disabled	☐ Y ☐ N	☐ Y ☐ N
• Employed	☐ Y ☐ N	☐ Y ☐ N
• Retired	☐ Y ☐ N	☐ Y ☐ N
• Self-Employed (submit Form 1040 and all Schedules)	☐ Y ☐ N	☐ Y ☐ N
• Student	☐ Y ☐ N	☐ Y ☐ N

INSURANCE INFORMATION

Do you currently have insurance that pays for all or part of your medical bills? ☐ Yes ☐ No

If yes, check all that apply:

☐ **Medicaid**: ☐ Traditional ☐ Texas Women's Medicaid
☐ **Medicare**: ☐ Part A ☐ Part B
☐ **Parkland Plus**
☐ **JPS Connect**
☐ **County Indigent Program**
☐ **Cancer Policy**
☐ **Private Insurance**: Check which applies and provide a copy of your insurance card
☐ Aetna ☐ BaylorScott & White Ins. ☐ Blue Cross Blue Shield (BCBS) ☐ Cigna
☐ Molina ☐ Parkland Ins. ☐ United Healthcare
☐ Other Insurance Provider ____

I agree that if my insurance situation changes, I will contact the Bridge Breast Network. Failure to contact the Bridge upon receiving benefits will result in paying back the Bridge for services rendered while insured. In addition you will be dismissed as a Bridge client.

CERTIFICATION OF INFORMATION: I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under Federal law, State law, or both and will be subject to immediate termination of services. I certify under penalty of perjury that the information provided on this application is true and complete to the best of my knowledge. If it is not, I will be subject to termination of services, repayment fees paid for by the Bridge Breast Network for my services received, and/or criminal prosecution. Your signature below authorizes use of the above information by the Bridge Breast Network to determine eligibility for services. This information will be kept in the strictest confidence and will only be used for program purposes.

______________________________ ______________________________
Signature **(parent/guardian if applicants under 18)** **Date**

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Monthly Income Amounts

Gross Wages	$ ______	VA Benefits	$ ______
Soc. Security	$ ______	Housing Auth.	$ ______
AFDC/TANF	$ ______	Workers Comp.	$ ______
SSI/ Disability	$ ______	Pension	$ ______
Unemployment	$ ______	Child Support:	$ ______

☐ Other: $______________

☐ Supporter Statement Attached

Total Monthly $ ______________

Rev. (10/2016)

Financial Assistance Policy & Release of Liability

Background Information

The Bridge Breast Network (BBN) is a non-profit organization funding diagnostic and treatment services for breast cancer to medically underserved women and men. Individuals must qualify for Bridge services by completing an intake form and meeting eligibility criteria.

Financial Assistance Policy

The BBN assumes no financial responsibility for any medical procedure unless the Case Manager has approved the procedure with the client and provider.

The BBN offers limited financial assistance to clients for diagnosis and treatment for breast cancer only. Every 6 months, the client will be asked to recertify for eligibility. A change in this information may disqualify a client for further services. If there is a reoccurrence of breast cancer, the client must requalify for assistance. Failure to provide the information will be reason for being dismissed as a Bridge client.

The BBN will refer clients to appropriate physicians and/or medical facilities in our network for diagnosis and treatment.

The BBN does not assume responsibility for diagnosis and treatment of metastatic breast cancer (breast cancer that has spread to other organs of the body). The BBN does not treat Fibroadenomas and/or other non-cancerous breast conditions unless specifically recommended by a physician to rule out a final cancer diagnosis.

Release of Liability

Waiver of Claims: The Bridge Breast Network is a 501c(3) non-profit corporation. Medical professionals donate their time on a voluntary basis. The services being provided might not be available but for the efforts of the BBN volunteers. The individuals provided services are not obligated to do so, but are doing so on a voluntary basis. The fair market of the services the client will receive far exceeds the amount she/he will be expected to pay.

The BBN has the right, in its sole discretion, to refuse to provide service or withdraw service in the event it determines that misrepresentation regarding information on the client's intake form have been made. In addition, the BBN may refuse or withdraw assistance for any other reason.

CLIENTS REQUIRING BREAST CANCER TREATMENT SERVICES

- **Copy of most recent IRS Income Tax Return must be submitted.**
- **The client is required to pay a portion of the cost for treatment services in the amount of $500 for each phase of treatment received through the BBN. Surgery: $500 / Medical Oncology: $500 / Radiation: $500. Initial payment of $1,000 required to begin treatment. Fees may be paid by check, cash, money order or credit/debit card. The credit/debit card processing fee is not included in the above totals.**

Initials _______

Consent Agreement

I, _________________________________, fully understand the conditions of the Bridge Breast Network's Financial Policy and Release of Liability.

I understand that by signing this form I am giving up my right to assert any claim or demand against the Bridge Breast Network for damages of any type arising out of the services provided to me through the effort and assistance of the Bridge Breast Network. In consideration for being permitted to receive the services provided, by signing below, I do forever release, hold harmless and discharge the Bridge Breast Network, its officers, directors, agents, volunteers, sponsors, employees, successors and assigns from any and all claims, causes of action, damages, demands or liability arising out of or connected in any manner arising out of my receipt of services.

By signing below, I acknowledge and agree that the Bridge's agreement to offer limited assistance for diagnosis and treatment of breast cancer does not obligate the Bridge to provide assistance for diagnosis and treatment for metastatic disease or any other related condition or illness.

By signing below, I acknowledge and agree that the Bridge has the right, in its sole discretion, to refuse to provide or withdraw assistance in the event it determines that misrepresentations regarding my intake information have been made. In addition, failure to comply with updating financial and demographic data when requested can result in being dismissed as a Bridge client.

I have carefully reviewed this agreement and am signing it of my own free will and not under duress or coercion of any kind. I am competent to sign this waver.

This release is made and intended to bind me as well as my heirs, executors, administrators, and assigns. This agreement is made in Texas and is intended to be construed under Texas law.

____ (Client's name printed)

_____________________________________ (Client's signature*) ______________ Date

____ (Witness's name printed)

_____________________________________ (Witness's signature) ______________ Date

*Signature **(parent or guardian for applicants under 18**

BRIDGE BREAST NETWORK

Authorization for Use and Disclosure of Protected Health Information

When you obtain services from any Bridge Breast Network provider, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. You may request a copy of the Bridge Privacy Policy and Practices at any time. You have the right to request that we restrict how protected health information about you is used.

I authorize the healthcare provider listed below to release my medical records and imaging studies to the Bridge Breast Network fax to: (214) 821-0869

	FOR OFFICE USE ONLY

I understand no information pertaining to my medical visits will be disclosed to anyone for purposes outside of normal treatment, payment, and program operations. I understand that I will be responsible for informing those people that I wish to be aware of reasons for my medical visits. Further, I understand The Bridge Breast Network and its providers are not responsible for any disclosures regarding my medical condition and/or treatments that are made by people that I inform.

1) This restriction will have no impact on the Bridge Breast Network right to disclose and use my protected health information for purposes of treatment, payment and health care operations.
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying the Bridge Breast Network in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) The Bridge Breast Network agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

☐ I authorize the Bridge Breast Network to use my story but not my full name for operational and fundraising purposes.

Additional Disclosure:

I also authorize The Bridge Breast Network to discuss my medical history, diagnosis and treatment with the following:

Relationship	Name	Phone Number
☐ Spouse	______________________	______________________
☐ Child	______________________	______________________
☐ Child	______________________	______________________
☐ Parent(s)	______________________	______________________
☐ Other: __________	______________________	______________________

Expiration:

This authorization will expire 180 days from the date of signing or **(insert date)** ______________________.

Patient Name: ______________________ **Patient ID #:** ______________________

______________________ ______________________

Signature of Patient or Legal Representative **Date**

______________________ ______________________

Printed Name of Patient's Representative (*if applicable*) **Relationship to Patient (*if applicable*)**

BRIDGE BREAST NETWORK

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ___________________________________ **Patient ID #:** ____________________

I hereby acknowledge that I have received a copy of Bridge Breast Network's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____

Signature of Patient or Legal Representative

____

Date

____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

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____

____

- ☐ Other (Specify)

____

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