______________________________________ ____________________ _____
Last Name First Name M I

____ Street
Address (No PO Box)

___________________________________ ______________ __________
City State Zip

____ _______________ ___________
Name and address of employer Work phone number Home number Cell number

_____ _____________ ___________________ __M______S_______D__
Age Birthdate Social Security Number Marital status/ circle one

____ ______________________
Name of insurance Policy number

Amount of Insurance Deductible____________ Yearly Out-of-pocket____________

Own or Rent home Own Rent Number of ***dependents*** reported to the IRS: ___

Net Income:_____ ________ per ***Year Month Week*** (circle one)
This is *Household income all sources*)
As reported the IRS on most recent tax return or most recent check stub
Proof of income required

(Check one) Screening Mammogram ____________ Diagnostic Mammogram____________

Patient/Client Physician:_______________________ ______________________________

Referring Doctor or Clinic if different from above: ___________________________________

_______________________________________ ____________________________
Address Phone number

***************"The undersigned Applicant does hereby certify that all of the information provided, as well as all statements made, in this Application are truthful, accurate, and complete to the best of the Applicant's knowledge, information, and belief. False information provided can be prosecuted to the full extent of the law. **************

_____________________________________ ____________________
Signature Date

____
Printed Name

____
IF patient/client unable to sign, guardian signature and relationship to patient/client

Thank you for your inquiry for assistance from Get A Mammy, Inc. Please fill out the form below and mail it to:
Get A Mammy, Inc.
PO BOX 3813
Valdosta, GA 31604
Form will not be accepted if not filled out in its entirety. Mark N/A where appropriate.