Bozeman Deaconess Health Services/AMI Mammogram Project

About the Reduced Income Mammogram Project

Thank you for your interest in the Bozeman Deaconess Health Services/AMI Mammogram Project. It is our goal to make this lifesaving detection procedure available to all women regardless of income. Funding is available for screening mammograms for women without insurance and underinsured women.
In order to qualify, women must meet the following criteria:

- Low income
- No health plan coverage or a health plan with prohibitively high co-pays for mammography

To Obtain a Voucher for Your Mammogram

Mail or fax the following to the Health Information Center:

- The attached completed application.
- Proof of income showing total household monthly income including spouse (e.g., most recent pay stub, or copy of unemployment check, or copy of financial aid check or copy of current taxes).
- A mammogram order or prescription form. (If you do not have this order please have your health care provider mail or fax to the Health Information Center.)

Mail application and supporting documentation to:
Bozeman Deaconess Health Information Center
915 Highland Blvd.
Bozeman, MT 59715

Fax application and supporting documentation to: (406) 414-1887 or email info@bdh-boz.com)

Qualifying Applicants/Scheduling Appointments

For those applicants who qualify for the program and have submitted all appropriate documents, a mammogram voucher will be mailed to you within seven business days. ***Once you've received your voucher, schedule your mammogram by calling Advanced Medical Imaging at (406) 414-5201.*** Please bring the mammogram voucher to your mammogram appointment. Vouchers are non-transferable and may only be used at Advanced Medical Imaging. The outcome of your mammogram is important to us. Therefore, you will receive a call from us in the future inquiring about the outcome of your appointment—your cooperation is appreciated, as it will help us to determine the effectiveness of our project.

For more information or questions about this program, call Bozeman Deaconess Health Information Center at (406) 414-1644.

Bozeman Deaconess Health Services/AMI Mammogram Project Application

Name: _____ Date: _____

Mailing Address: _____

_____

Date of Birth: _____ Phone: ( ) _____

Use the following table to determine your eligibility.

	1 Person	2 People	3 People	4 People	5 People
Income Level	Up to $2206/mo	Up to $2977/mo	Up to $3748/mo	Up to $4519/mo	Up to $5379/mo

Number of people in household, including yourself: _____

Monthly gross income of all adults: $ _____

Do you have health insurance that may cover part of this service? ☐Yes ☐No

Have you had a mammogram before? ☐Yes ☐No

Date of last mammogram: _____

Would you care to make a donation to the Mammogram Project? ☐Yes ☐No

(Please make check out to "BDF" and submit with your application or mail to address below)

***How did you hear about the program?* (*Please check all that apply*)**

☐ Doctor, Nurse ☐ Friend or Relative ☐ TV, Radio, Newspaper

☐ Health Fair ☐ Re-screen/ Previously Enrolled ☐ Other: _____

Before submitting application, please ensure you have provided:

☐ Proof of income showing total household monthly income including spouse

☐ Mammogram order or prescription (mail a copy to address below or fax to 406-414-1887 or send an email to info@bdh-boz.com)

Mail application to:

Bozeman Deaconess Health Information Center
915 Highland Blvd.
Bozeman, MT 59715

Bozeman Deaconess Health Services Advanced Medical Imaging make this program possible.

For Internal Use Only

Date received ___/___/___ ☐ Proof of income ☐ Mammogram order ☐ Donation ck#_____

Project eligible _____ Initial _____ Voucher sent ___/___/___