SOLANO MIDNIGHT SUN FOUNDATION

795 Alamo Drive, Ste. 106 · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 320-0018 website: http://www.solanomidnightsun.org

Breast Health Program 2024

Date of Application _____

DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City, State Zip: _____

Phone number: Home: _____ Work: _____

Cell Phone: _____ Other: _____

E-Mail: _____

Ethnicity: _____ Preferred Language: _____

MARITAL STATUS (please circle)

1. Married **2. Never Married** **3. Separated** **4. Divorced**

5. Widow (er) **6. Other**_____

What medical insurance do you have? (Private, Medicare, MediCal, BCCTP, etc.)_____

_____

_____

Did someone help you with this application: ☐ Yes ☐ No

Name:_____Relationship:_____

Phone Number:_____Email:_____

☐ Please check this box if you would like to be referred to other agencies for possible assistance. Referrals may result in sharing your information between SMSF and other agencies.

By signing below, I agree that the above information is true and correct.

_____ _____

Signature Date

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APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

To: _____

Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: _____

_____

_____

_____

I, _____, residing at _____

_____

_____

hereby authorize you to release to Solano Midnight Sun Foundation, non-profit organization (68-0354961) specific information requested by them which I cannot provide concerning:

_____

_____

_____

_____

This information is needed to determine my eligibility for assistance from Solano Midnight Sun Foundation (SMSF) I have read this form and have agreed to its request prior to my signing.

_____	_____
Print name	Social Security Number
_____	_____
Date of birth	Birthplace
_____	_____
Signature of Applicant	Date
_____	_____
Signature of Witness	Date

Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Solano Midnight Sun Foundation.