Application

Please review the criteria for the ARTfullAngels' financial assistance program before applying.

The application should be filled out and authorized by an appropriate referral source, a social worker, patient navigator or case manager. If questions regarding this, kindly contact ARTfullAngels.
Please print clearly.

Patient Contact Information

First and Last Name: _____

Address: _____

City, State Zip: _____ County: _____

Home/ Cell phone: _____ Email: _____

Date of birth: _____

Patient Signature: _____

Application Date: _____

Referral Information:

☐ **for Hippa privacy rule, please check if you allow for a referral**

(Social Worker, Patient Navigator, Case Manager must fill out)

First and Last Name: _____

Position: _____

Facility: _____

Address: _____

City, State Zip: _____

Telephone: _____ Email: _____

As the medical referral, my signature attests to the accuracy of the medical information about this patient.

Referral Signature: _____

Title: _____ Date: _____

Biographical Information

How to reach you? Cell / Work best time? _____

Marital Status: (circle) Single Married Separated Divorced Widowed

Of Children: _____ Ages: _____ Do you live alone? _____ # of Adults home? _____

Language(s) Spoken: (circle) English Spanish Creole Other

Please tell us your reason for applying to ARTfullAngels: _____

_____

_____

How did you hear about ARTfullAngels: _____

Name of person who referred you: _____

Referring person's telephone: _____

Monthly household income _____

Financial assistance from ARTfullAngels is for breast cancer mammography

www.artfullangels.org

Submit application to: artfullangels@gmail.com

Or mail to

P.O. Box 590071
Ft. Lauderdale, Florida 33319-2951