SURROUNDED *by* HOPE

Joan Katz Breast Center/Survivor Gals
PATIENT FINANCIAL SCREENING FORM
(Please Print Clearly)

Today's date:

PATIENT INFORMATION

Last name: | First: | Middle:

DOB: | Age: | Sex: ☐ M ☐ F | E-mail Address: | Home phone no.:

SSN:

Street address: | PO Box: | Alternate phone no.:

City: | State: Select. | ZIP Code:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

☐ Uninsured ☐ Private Insurance
☐ Medicare #
☐ Medicaid #
☐ JPS Connection #

Diagnosis:

Treating Physician:

Medical Oncologist:

Radiation Oncologist:

Date of surgery:

Current or Planned Cancer Treatments:

Additional Info:

Current Medications:

Additional Sites or Mets:

Ethnicity:
☐ American Indian ☐ Asian
☐ Black or AA ☐ White
☐ Hispanic/Latino ☐ Multiracial
☐ Decline ☐ Other

Referred by.

Patient/Guardian signature

Date

Total Number of People in Household

Net Household Monthly Income

Income Source	Client $	Spouse $	Other Household $
Employment			
Child Support			
Disability			
Food Stamps			
Housing Allowance			
Interest or investments			
VA/other Income			
Retirement			
SSR, SSI, SSD			
Unemployment			

Income verification: Please provide verification (**send only copies, no original documentation**) for all sources of household income (acceptable documentation listed below).

Check attached documents

☐ Paycheck Remittance ☐ IRS Form W-2 ☐ Bank Statements ☐ Employer Verification ☐ Tax Return

☐ Government Assistance (food stamps, CDIC, Medicaid)

☐ Social Security, Workers Comp, or Unemployment Determination Letters ☐ Other

Total Combined Monthly Income $

Product	Product Description	Quantity
Wigs		
Right Prosthesis		
Left Prosthesis		
Bilateral Prosthesis		
Bra		
Other		
Other		

Proof of Income Attached? ○ Yes ○ No

Name of Person Completing Form Date

Patient Signature.

JKBC USE ONLY

Patient Approved ○ Yes ○ No Authorization Signature _____ Date: _____