Embracing U
Non-profit Breast Cancer Foundation

BREAST CANCER/BREAST HEALTH ASSISTANCE PROGRAM

Do you have a referral or a prescription for a mammogram, biopsy or ultrasound?
□ Yes □ No

Do you have a primary care physician (PCP, regular doctor)?
□ Yes □ No

Do you currently have a lump or abnormality in either breast?
□ Yes □ No

PERSONAL INFORMATION (PRINT CLEARLY)		
First Name:		Last Name:
Date of birth (M/D/Y):	Phone:	Email:
Current address:		
City:	State:	ZIP Code:
ASSISTANCE REQUESTED (CHECK ONE)		
Have you received assistance from Embracing U in the last 12 months? ☐ Yes ☐ No		
FINANCIAL STATUS		
Are you currently employed? ☐ Yes ☐ No	If **NO**, state reason:	
List sources of income:		
Amount of Request: $	Head of Household ☐ Yes ☐ No	Number in Household:
Name of Business Vendor to Receive Payment:	Business/Vendor Address: Phone:	Business/Vendor Account Number:
Annual Household Income ☐under $25K ☐ $25K-$49,999 ☐ $50K-$69K ☐ $70K		
Explain circumstances creating financial need at this time:		
HOW DID YOU HEAR EMBRACING U FOUNDATION?		
Referred by:		
Contact Name	Contact Email	Contact Phone
OFFICE USE ONLY		
VERIFICATION DATE:	SCAN DATE	FACILITY: CONTACT NAME:

PLEASE EMAIL APPLICATION TO:
embracingu_3@yahoo.com
Or Mail To:
Embracing U Foundation • PO Box 13206 • Charleston, SC 29422

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