



West Valley Medical Center  
Mammography Suite  
1717 Arlington Avenue  
Caldwell, ID 83605  
(208) 459-4641

Client Name (Last, First, M.I.)

\_\_\_\_\_

Social Security # \_\_\_\_\_

Date of birth: ( \_\_\_\_ / \_\_\_\_ / \_\_\_\_ )  
Mo Day Year

Home mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Daytime phone #: \_\_\_\_\_

Cell#: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Is there someone we may contact in case we cannot reach you?

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**Client Eligibility**

- Total household income before taxes  
\$ \_\_\_\_\_ annually/ \_\_\_\_\_ monthly
- Total number living in household for this income \_\_\_\_\_
- Number of children under 19 living with you \_\_\_\_\_
- Do you have a spouse who is currently living with you? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have insurance that covers a mammogram? Yes \_\_\_\_\_ No \_\_\_\_\_
- Are you covered by Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_
- Are you age 25-65? Yes \_\_\_\_\_ No \_\_\_\_\_

*(for internal use only)*

Client Eligibility based on:

\_\_\_\_\_ Income Guidelines

\_\_\_\_\_ No insurance

\_\_\_\_\_ Age 25-49

**RN** \_\_\_\_\_

Consent for Release of Information and Statement of Confidentiality

**West Valley Medical Center** must collect information from all grant participants to receive funding from the Tough Enough For Pink Foundation. By agreeing to take part in the grant, I give permission to any and all of my health care providers, clinics, and/or hospitals to provide all information concerning breast exams and mammograms, and any related care to the program and Cancer Data Registry of Idaho. Any published reports will not identify me by name. I understand that notifying me of results is a very important purpose for the program, and all available resources may be used to notify me if I have an abnormal result. I agree to have a breast exam, mammogram, and any diagnostic tests determined necessary. I understand that knowingly providing false information may result in criminal, civil, or administrative action.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_