



Name: _____

Date of Birth : _____ (must be prior to 1970 to be eligible)

Daytime Phone Number: _____ Cell Number: _____

Preferred Language: _____

Well Woman Healthcheck
Quick Eligibility Determination

Are you at least 40 years of age? **YES / NO**

Are you eligible for or to apply for AHCCCS or Medicare Part B? **YES / NO**

Are you insured for mammography services costing \$100 or more? (Co-pay) **YES / NO**

How many people live in your household including yourself? _____

FAMILY SIZE	MONTHLY INCOME	ANNUAL INCOME
1	\$902 up to \$2,256	\$10,830 up to \$27,075
2	\$1,214 up to \$3,035	\$14,570 up to \$36,425
3	\$1,525 up to \$3,814	\$18,310 up to \$45,775
4	\$1,837 up to \$4,593	\$22,050 up to \$55,125
5	\$2,149 up to \$5,372	\$25,790 up to \$64,475
6	\$2,460 up to \$6,152	\$29,530 up to \$73,825
7	\$2,772 up to \$6,931	\$33,270 up to \$83,175
8	\$3,084 up to \$7,710	\$37,010 up to \$92,525

Each Additional Person \$312 per month \$9,350 per year
--

What is your gross household income (before taxes)? _____ per Week / Month / Year

(Must meet above income guidelines to qualify)

The information I have provided on this form is correct. I understand that if I have provided false information, I may be responsible for all charges resulting from the services I have received and that I may not be able to receive future services from the Well Woman Healthcheck Program.

SIGNATURE: _____ DATE: _____

EVENT: <u>PINK 365</u>	LOCATION: _____	DATE: _____
-------------------------------	-----------------	-------------