

# **SOLANO MIDNIGHT SUN FOUNDATION**

795 Alamo Drive, Suite 106 · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

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## **Breast Health Program 2009-10**

**Date of Application** \_\_\_\_\_

### **DEMOGRAPHIC INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

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

Phone number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

### **MARITAL STATUS (please circle)**

**1. Married**

**2. Never Married**

**3. Separated**

**4. Divorced**

**5. Widow (er)**

**6. Other** \_\_\_\_\_

What medical insurance do you have? (Private, Medicare, MediCal, BCCTP, etc.) \_\_\_\_\_

Doctor's name making your referral: \_\_\_\_\_

Did someone help you complete this form? Y N

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

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Please check this box if you would like to be referred to other agencies for possible assistance. Referrals may result in sharing your information between SMSF and other agencies.

By signing below, I agree that the above information is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## **Breast Health Program 2009-10**

### **APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION**

To: \_\_\_\_\_  
Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, residing at \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

hereby authorize you to release to Solano Midnight Sun Foundation, non-profit organization  
(68-0354961) specific information requested by them which I cannot provide concerning:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is needed to determine my eligibility for assistance from Solano Midnight Sun Foundation  
(SMSF) I have read this form and have agreed to its request prior to my signing.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Birthplace

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Note: Provide this form to the physician or other agency from whom you are requesting the release of information to  
Solano Midnight Sun Foundation.**