

SOLANO MIDNIGHT SUN FOUNDATION

795 Alamo Drive, Ste. 106 · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 320-0018

website: <http://www.solanomidnightsun.org>

Breast Health Program 2026-27

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 (Check one)

☐ Married

☐ Never Married

☐ Separated

☐ Divorced

☐ Widowed

☐ Other _____

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

Did someone help you with this application: ☐ Yes ☐ No

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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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.