NorCal Think Pink
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Application for Breast Cancer Detection Funds (BCDF)

Dear Nor-Cal Think Pink Breast Cancer Detection Fund Review Committee:

I am writing to request assistance through the Breast Cancer Detection Funds (BCDF) to help cover the cost of diagnostic testing recommended by my healthcare provider.

Following [an abnormal screening / the discovery of a lump / my family history of breast cancer], my provider has advised further testing—such as a mammogram, ultrasound, or biopsy—to ensure early detection and accurate diagnosis. These next steps are important to my health, and I am committed to following all medical recommendations.

While I am prepared to move forward with this care, the cost of testing presents an added burden during an already stressful time. Support from Nor-Cal Think Pink would help ease that burden and allow me to focus fully on my health and well-being.

I would be grateful for your assistance and am happy to provide any necessary documentation, including the medical recommendation, my name, address, and identification.

Thank you for your time, consideration, and the vital support you offer through this program.

Sincerely,

**Requester's information:**

Name:_____

Mailing Address:_____

Phone Number:_____ Email:_____

Please explain the reason for your request in a few words (initial screening results, family history, etc): _____

_____

Further tests Required:

- ☐ Screening Mammogram (Bilateral or Unilateral)
- ☐ Unilateral Diagnostic Mammogram
- ☐ Bilateral Diagnostic Mammogram
- ☐ Unilateral Breast Ultrasound
- ☐ Bilateral Breast Ultrasound
- ☐ Stereotactic Breast Biopsy
- ☐ Breast Biopsy - Additional Lesions
- ☐ Ultrasound Guided - Right Breast
- ☐ Ultrasound Guided - Left Breast
- ☐ Cyst Aspiration - Right Breast
- ☐ Cyst Aspiration - Left Breast
- ☐ Single Duct Galactogram
- ☐ Multiple Duct Galactogram
- ☐ Breast MRI

Ordering Medical Provider:_____

**Patient Race**

- ☐ Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ Native American
- ☐ Hispanic
- ☐ Other
- ☐ Do not wish to answer

**Patient Age**

_____

**Patient Employment**

- ☐ Employed
- ☐ Unemployed
- ☐ Disabled
- ☐ Retired
- ☐ Student

**Patient Sex**

- ☐ Female
- ☐ Male