American Italian Cancer FOUNDATION
No-Cost Breast Cancer Screening

MOBILE NO-COST BREAST CANCER SCREENING PROGRAM APPLICATION

ORGANIZATION

Organization Name: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

CONTACT PERSON

Name & Title: _____

Phone: _____ Fax: _____

Email: _____

Supervisor Name & Phone: _____

Name & Cell # for Person on Screening Day (required):

_____

_____

SCREENING DAY

Requested Date (Please list your top 4 choices):
We screen Tuesday through Saturday 9am-5pm

1. _____ (9am-5pm)
2. _____ (9am-5pm)
3. _____ (9am-5pm)
4. _____ (9am-5pm)

*Please note that we screen 10am – 5pm for Manhattan sites only

112 E. 71st Street, Suite 2B, New York, NY 10021 • (212) 628-9090 phone • (212) 517-6089 fax

American Italian Cancer FOUNDATION
No-Cost Breast Cancer Screening

SCREENING LOCATION (if different than organization address)

Location Name: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please describe how to arrive to screening location via public transportation. Please include the nearest train/bus stops and the approximate number of blocks the patient will need to walk from this stop to the screening location. Attach separate sheet if necessary.

_____

_____

_____

_____

CARE CLINIC PARKING REQUIREMENTS

Our no-cost breast cancer screening services take place inside our van which is 32 ft x 7.5 ft. You **must reserve 40 feet of parking** (approximately **4 parking spaces**) for the van on the screening day. The parking space should be on **level ground**. There cannot be a fire hydrant in the designated parking spot. Additionally, for the safety of the women being screened, parking should be arranged so that the **passenger side of the van (right side of the van) will not face oncoming traffic.** This means that if you are located on a one-way street and your site is on the left side of the street, you must reserve parking on the **right side** of the street so that the patients can safely enter and exit from the sidewalk. Your local police precinct will be able to assist you with no-parking signs. Please post no-parking signs **48 hours prior** to screening day.

APPOINTMENTS

The American-Italian Cancer Foundation (AICF) requires you to submit a list of **25 women and phone numbers** interested in getting their mammograms. This list should be submitted to AICF **at least two weeks prior** to the screening date. Please note that some women from the submitted list may not be eligible for our program.

☐ Yes, my organization will collect at least 25 appointments by: _____

112 E. 71st Street, Suite 2B, New York, NY 10021 • (212) 628-9090 phone • (212) 517-6089 fax

LANGUAGE

What languages, other than English, are spoken by the target population?
☐ Spanish ☐ Chinese ☐ Russian ☐ Creole ☐ Bengali ☐ Korean

Will you be able to provide an interpreter for the women attending the screening? ☐ Yes ☐ No

HEALTH EDUCATION

An AICF representative may be on-site the day of the screening to hand out educational material and answer patients' questions.

Would you like an AICF representative to give a presentation before the visit?
☐ Yes ☐ No

COMMUNITY OUTREACH

Please list 3 organizations within your neighborhood or community serving a large number of women. This could consist of nearby churches, schools, cultural centers, etc. The purpose of this section is to collect information that would allow AICF staff to reach out to nearby organizations in order to promote your upcoming screening

	Organization Name & Website	**Contact Person**	**Contact Number & Email Address**
1.			
2.			
3.			

COMMUNITY SITE RESPONSIBILITIES

112 E. 71st Street, Suite 2B, New York, NY 10021 • (212) 628-9090 phone • (212) 517-6089 fax

American Italian Cancer FOUNDATION
No-Cost Breast Cancer Screening

(Please keep a copy for yourself)

AGREEMENT

As an authorized representative of _____ ,
[Name of Organization]

I agree to host AICF's Mobile No-Cost Breast Cancer Screening Program. I acknowledge that all services are provided at no-cost to my site and the women we serve. In return, my organization agrees to:

INITIAL

____ *Provide AICF with at least 25 names and phone numbers 2 weeks prior to the screening.*

____ *Reserve legal parking space for the mobile CareClinic. Secure parking spot by displaying parking permit near assigned parking spot at least* ***48 hours before the event.*** *Be sure that there is no fire hydrant in the designated parking spot. Be sure the passenger side (the right side of the van) of the van will not be facing oncoming traffic.*

____ *Provide a bathroom for the screening staff until the end of the screening day.*

____ *Provide a waiting area for the patients, particularly in inclement weather.*

____ *Provide a volunteer (bilingual if the majority of the population speaks a language other than English) to assist patients with paperwork for the first 3 hours of the screening.*

I understand that if these conditions are not met, the visit to my site may be cancelled or postponed. Furthermore, I understand that:

INITIAL

____ *The Program is only open to women age 40 and older who live in NYC and have not had a mammogram in the last 12 months.*

____ *Women with health insurance including Medicare and Medicaid must bring insurance cards to receive* services.

____*Traffic and weather conditions may delay the arrival of the vehicle and could cause the screening to be cancelled or postponed.*

In addition to the names collected by my organization, AICF may also make appointments through their 1-877 number.

_____ _____
Signature Date

_____
Print Name

112 E. 71st Street, Suite 2B, New York, NY 10021 • (212) 628-9090 phone • (212) 517-6089 fax