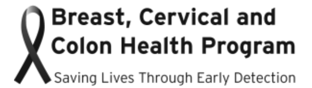
DOH 342-054 February 2018

SPOKANE REGIONAL HEALTH DISTRICT
PHONE 509-323-2851 FAX 509-324-1599
WWW.SRHD.ORG



BCCHP ENROLLMENT FORM

Please Print **New to BCCHP?** ☐ Yes ☐ No **Authorization #**

Last Name	First Name	MI	Authorized for: ☐ CBE ☐ Pelvic ☐ Pap ☐ Mammogram ☐ FOBT/FIT ☐ Colonoscopy

Gender: ☐ Female ☐ Male ☐ Transman ☐ Transwoman ☐ Genderqueer ☐ Gender Non-Binary ☐ Agender ☐ _______

Services of interest: ☐ Breast ☐ Cervical ☐ Colon

Prime Contractor	Date
SPOK	

Date of Birth	Last 4 Digits SSN (Optional)	Clinic / Screening Site

Address	Appointment Date: Time:

City	State	Zip Code	County	Clinic Chart #

Telephone Numbers: OK to leave a message? ☐ Yes ☐ No **Best time to call:** ☐ a.m. ☐ p.m.

Home: **Cell:** **Work:** **Alternate:**

Program Eligibility: must be completed annually

Household income before taxes? $ _____ Per ☐ Month ☐ Year How many people live on this income? _____

Checked eligibility for Apple Health ☐ Yes ☐ No (reason _____) Date:
Eligible for Apple Health ☐ Yes ☐ No Enrolled on Apple Health ☐ Yes ☐ No Date:

Do you have? (select all that apply) ☐ **No Health Insurance & Not Eligible for Apple Health (attach denial if available)**
☐ **Medicare Part B** ☐ **Apple Health, Medicaid, Provider One # _____**
☐ **Insurance Name of company: _____ Deductible: $_____ Policy/ID #: _____**

Do you have? ☐ **a breast symptom** ☐ **colorectal symptoms** ☐ **a family history of colon cancer or colon polyps**
Have you had a colonoscopy in the past? ☐ **No** ☐ **Yes If yes, When? _____**

Primary Language? (check all that apply, circle prefer) ☐ **English** ☐ **Spanish** ☐ **Vietnamese** ☐ **Chinese** ☐ **Korean**
☐ **Cambodian** ☐ **Russian** ☐ **Other (specify:)** **Do you need an interpreter?** ☐ **No** ☐ **Yes**

What race do you think of yourself? (Mark one or more)
☐ **Asian** ☐ **Black or African American** ☐ **American Indian or Alaska Native (specify tribe:)**
☐ **White or Caucasian** ☐ **Native Hawaiian or other Pacific Islander (specify:)** ☐ **Unknown**
Are you Latino or Hispanic? ☐ **Yes** ☐ **No**

What is the highest grade of school you have completed? (number of school years) _____

If you are NEW to BCCHP, how did you learn about this program? (select only one)

For persons with disabilities, this document is available on request in other formats.
To submit a request, call 1-800-525-0127 (TDD/TTY call 711).

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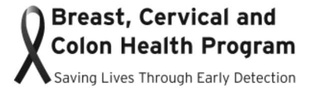

☐ **Clinic**	☐ **Friend or relative**	☐ **Radio**
☐ **Community organization**	☐ **Internet search – BCCHP website**	☐ **Radiology dept.**
☐ **Employer**	☐ **Mailing**	☐ **TV**
☐ **Outreach worker**	☐ **Poster, Flyer or Brochure**	☐ **Other (specify):** ____________

Please FAX form to BCCHP Prime Contractor at:

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