Washington State Department of Health

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*SPOKANE REGIONAL HEALTH DISTRICT*
*PHONE 509-323-2851 FAX 509-324-1408*
*WWW.SRHD.ORG*

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

# BREAST & CERVICAL CANCER TREATMENT PROGRAM ELIGIBILITY, RELEASE AND CONSENT FORM

***Please Print*** ***FOR OFFICE USE ONLY***

| **Last Name** | **First Name** | **MI** | **BCCHP Prime Contractor** | **Diagnosis Date** |
|---|---|---|---|---|
| **Date of Birth** | **Social Security Number** | | **BCCHP Case Manager Name:** | |
| **Address** | | | **BCCHP Case Manager Phone:** **Fax:** | |
| **City** | **State** | **Zip Code** | **BCCHP ID #** | **Medicaid ID #** |
| **Telephone Numbers:** **OK to leave a message?** ☐ **Yes** ☐ **No** **Home:** **Cell:** **Work:** **Alternate:** | | | **Clinic Chart #** | **Clinic Name** |

***What is your household income before taxes?*** **$ _____** **per** ☐ **Week** ☐ **Month** ☐ **Year**

***Number of people living in household being supported on household income:*** **_____**

***Do you have health insurance?*** ☐ **Yes** ☐ **No** **If Yes, Company:_____** **Policy #_____**

***Do you have unpaid medical bills from this breast or cervical cancer diagnosis?*** ☐ **Yes** ☐ **No**

**If Yes:** # of months before your diagnosis date that the testing began and was not covered by BCCHP or insurance**:** ☐ **1** ☐ **2** ☐ **3**

***Are you a Washington state resident*** ☐ **Yes** ☐ **No**

***Are you a U.S. citizen?*** ☐ **Yes** ☐ **No** ***Where were you born?*** State: _____ Country: _____

***Are you a U.S. Permanent Resident?*** ☐ **Yes** ☐ **No** ☐ **Not Applicable**

**Permanent Resident since: (date on P.R. card)** _____ *If born **outside of the U.S.**, provide immigration documents **once***

**Primary Language?** (check all that apply, circle the one you prefer) ☐ **English** ☐ **Spanish**

☐ **Vietnamese** ☐ **Chinese** ☐ **Korean** ☐ **Cambodian** ☐ **Russian** ☐ **Other (specify: _____ )**

**I understand that: (please initial each statement)**

____ I am being referred to the Washington State Health Care Authority (HCA) Apple Health Medicaid Program for medical coverage for breast or cervical cancer treatment.

____ This information will not be shared with the U.S. Citizenship and Immigration Services (USCIS).

____ I give the Breast Cervical & Colon Health Program (BCCHP) release of medical records for documentation of treatment.

____ I give the State of Washington rights to any medical support benefits and to any third party payments for health care.

**I have read and understand the above information. I declare, under penalty of perjury, the information I have provided is true, correct, and complete to the best of my knowledge.**

**Client Signature:** _____ **Date**:_____

**Case Manager Signature:** _____ **Date:**_____

**FOR BCCHP CASE MANAGER USE:**

Initial eligibility screening date: _____ Re-verification date**:** _____ Remains eligible: ☐ **Yes** ☐ **No** (If no, explain in notes)

Requested coverage start date: _____ **AEM / ERSO:** ☐ **Yes** ☐ **No** **BCCHP** Consent form current: ☐ **Yes** ☐ **No**

*Case Management Notes:*

**Updated 10-01-2015**