Washington State Department of Health

Public Health
Seattle & King County

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

DOH 345-214 Feb 2018

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: 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**

Were you born in a US Territory? **☐ Yes ☐ No Where?_____**

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

Permanent Resident since: (date on P.R. card) _____ (It is only necessary to copy PR card once for initial app, not for renewals)

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

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

Do you need an interpreter? ☐ Yes ☐ No

I understand that:

- 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: