Washington State Department of Health

Public Health Seattle & King County

Breast Cervical & Colon Health Program
401 5th Ave #1110, Seattle WA 98104
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Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

DOH 342-054 July2020

BCCHP ENROLLMENT FORM

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

Last Name	First Name	MI	Authorized for: ☐ CBE ☐ Pelvic ☐ Pap ☐ Mammogram

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

Services of interest: ☐ Breast ☐ Cervical

Prime Contractor	Date

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 any problems with your breasts? ☐ Yes ☐ No If yes, what problem? ___________________________

____

Primary Language? (check all that apply, circle prefer) ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Korean

☐ Cambodian ☐ Russian ☐ Other (specify:) Do you need an interpreter? ☐ Yes ☐ No

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

Do you consider yourself Latina/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)

☐ 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:

To request this document in another format, call 1-800-525-0127.
Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.