Cancer Detection Programs: Every Woman Counts

RECIPIENT ELIGIBILITY FORM

Cancer Detection Programs: Every Woman Counts

Top section to be completed by patient

Patient ID | | | 9 | A | | | | | | | | | |

1. Last Name

2. First Name

3. Middle Initial

4. Mother's Maiden Name

5. Date of birth (Month--MM) (Day--DD) (Year--YYYY)

6. Address

7. City

8. State

9. ZIP Code

10. Telephone

11. Are you Hispanic or Latino?
- ☐ Yes
- ☐ No

12. Select all that apply to you
- ☐ American Indian or Alaska Native
- ☐ Asian → 13. (Select one if Asian)
  - ☐ Asian Indian
  - ☐ Cambodian
  - ☐ Chinese
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American
- ☐ Pacific Islander → 14. (Select one if Pacific Islander)
  - ☐ Filipino
  - ☐ Guamanian
  - ☐ Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ Unknown

15. Total number of family members living together (applicant, spouse, children aged 20 and younger):

16. Total gross monthly income of family members:

17. I have no health insurance: ☐ None

I have this kind of health insurance:
- ☐ Medi-Cal
- ☐ Military
- ☐ Private insurance
- ☐ Medicare Part B
- ☐ Family PACT
- ☐ Other _____

I certify that the above information is correct and complete:

Recipient signature _____ Date Signed _____

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

18. ☐ Meets program's age criteria for breast and cervical cancer screening and diagnostic programs.
[≥ 40 years of age for Breast Services or ≥ 25 years of age for Cervical Services]

19. ☐ Meets program's income and insurance criteria for breast and cervical cancer screening and diagnostic programs.
[≤ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]

20. ☐ Recipient referred for Breast and Cervical Cancer Treatment Program (Optional).

21. ☐ Signed program's consent form.

I have determined that this woman is eligible for CDP services*.

Primary Care Provider Staff Certifying Signature _____ Date Certified _____

To be eligible for program participation, clients must meet age, income and health insurance criteria. All three must be met for eligibility

**Eligibility determination policies and information are located in the Cancer Detection Programs' Section of the Medi-Cal Manual.*

Complete all fields. Place original in patient chart

Eligibility Form (10/07)