Washington State Department of Health
Public Health Seattle & King County
BCCHP-Prevention Division
401-5th Ave Suite 900, Seattle, WA 98104
206-263-8176, fax- 206-296-0208
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** **SEAT**	**Diagnosis Date**
Date of Birth	**Social Security Number**		**BCCHP Case Manager** **Name: Heather Fluegel**	
Address			**BCCHP Case Manager** **Phone: 206-263-8176 Fax: 206-296-0208**	
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**:***

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).