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

ENROLLMENT FORM

Please Print **New to BCCHP?** ☐ **Yes** ☐ **No** ☐ **Female** ☐ **Male** **Authorization #**

Last Name	**First Name**	**MI**	**Authorized for:** ☐ **CBE** ☐ **Pelvic** ☐ **Pap** ☐ **Mammogram** ☐ **FOBT/FIT** ☐ **Colonoscopy**
Previous Name			**Prime Contractor** / **Date**
Date of Birth	**Social Security Number**		**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, ProviderOne, or medical coupons # _____**

☐ **Insurance** **Name of company: _____** **Deductible: $_____** **Policy/ID #: _____**

Do you have? ☐ **a breast symptom** ☐ **colorectal symptoms** ☐ **a family history of colon cancer or colon polyps**

Have you had a colonoscopy in the past? ☐ **No** ☐ **Yes** **When? _____**

Birth country: ☐ **USA: State:** ☐ **Other** (specify:)

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

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

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**

Are you 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)

☐ **Brochure**	☐ **Friend or relative**	☐ **Poster**
☐ **Clinic**	☐ **Internet search – BCCHP website**	☐ **Radio**
☐ **Community organization**	☐ **Komen for the Cure**	☐ **Radiology dept**
☐ **Employer**	☐ **Mailing**	☐ **TV**
☐ **Event**	☐ **Newspaper**	☐ **Other (specify):** _____
☐ **Flyer**	☐ **Outreach worker**	

Please FAX form to BCCHP Prime Contractor at: 206-296-0208

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).