Version: October 2012





Mail completed form to:

Wyoming Breast and Cervical Cancer Early Detection Program
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002
1-800-264-1296 (phone)
Fax 1-307-777-3765

Web address: www.health.wyo.gov/PHSD/bccedp

Insurance: Do you have health insurance? Do you have Medicaid (Title 19)? Do you have Medicare Part B?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Personal Information	Risk Factors - Circle responses.
First Name: Middle Initial: Last Name: Maiden Name: Date of Birth: Address: City: Mailing Address: (if different than above)	If so, was your cervix removed? Yes No Don't Know 3. When was your last Pap test? Was it abnormal? Yes No **If yes, see instructions below for
City: Zip: County: Home Phone: Cell Phone: Work Phone: Social Security Number: (optional)	required report. 6. When was your last clinical breast exam?
Office Use Only Approved Initials: Denied Initials: Date:	 7. Was it abnormal? <i>Yes No</i> **If yes, see instructions below for required report. 8. Have you had breast cancer? <i>Yes No</i> If yes, when?
State ID #: Staff Notes:	Your current monthly household income: Number of people in household supported by this income: Note: If your income varies from month to month, average the last three months. If you are self employed, please indicate income after business expenses.

**If you have had an abnormal clinical breast exam, Pap test and/or mammogram within the last three months, please request a copy of the report from your healthcare provider and mail or fax the report in with your application. If the report is not included, processing of your application will be delayed.

Race/Ethnicity	Consent, Release, & Confidentially Statement
Are you Hispanic or Latino? Yes No Check one or more: White Black or African American American Indian, Alaska Native Asian Native Hawaiian or Other Pacific Islander Other:	The information I have provided is accurate to the best of my knowledge. I understand that if I am accepted into this program, and I have knowingly provided false information, I may be required to repay any benefits I have received. I understand that I could be prosecuted for fraud if: (a) I have provided false information and/or (b) any changes to my income and/or insurance status are not reported after I am enrolled. By agreeing to take part in this program, I give my permission to healthcare providers, billing agencies, Wyoming Department of Health, Wyoming Breast and Cervical Cancer Early Detection Program, the Centers
Your Health Care Provider (if applicable)	for Disease Control and Prevention, and others involved in my care to share medical information obtained for
Clinic Name:Address: Zip: Zip:	the purpose of screening, diagnosis, treatment, and program evaluation. I understand that information received by the
Alternate Contact ~ Someone who does not live with you.	Wyoming Department of Health (WDH) policies. For additional information regarding WDH uses and disclosures of protected health information, visit the
Name: Street Address: Zip: Zip: Relationship:	

<u>This form must be submitted within 30 days of your signature above</u>. Please take the time to review this form, be sure all questions are answered, you have signed it, and have enclosed any required reports. <u>Incomplete applications can not be processed</u>. *If you need help completing this form call 1-800-264-1296 and press Option # 1 for assistance*. Form may be faxed to us to expedite process (fax:307-777-3765). *Thank you!*