



# Enrollment Application Checklist

Check box or boxes for which program you chose to enroll

- Wyoming Breast & Cervical Cancer Program (WBCC) *(free mammogram & Pap test)*
- Wyoming Colorectal Screening Program (WCCSP) *(free colonoscopy)*

Read, complete and sign the following documents:

**Enrollment Application**

- ❖ Answer all questions for the procedure(s) you are applying for
- ❖ Please print clearly in blue or black ink

Please submit the application by mail or fax:

Mailing Address: Wyoming Integrated Cancer Services  
 6101 Yellowstone Road, Suite 510  
 Cheyenne, WY 82002

Fax: (307) 777-3765

Phone: (307) 777-3699 or 1-800-264-1296

Website: [www.health.wyo.gov/publichealth/prevention/cancer](http://www.health.wyo.gov/publichealth/prevention/cancer)

**2016 Federal Poverty Guidelines**

Income guidelines used to determine eligibility if you qualify for a free colonoscopy or Pap test and Mammogram

*(Based on gross income before taxes are removed):*

Number of Persons in Family Unit	250% Poverty Guidelines	Monthly	Hourly
1	\$29,700	\$2,475	\$14.29
2	\$40,050	\$3,338	\$19.27
3	\$50,400	\$4,200	\$24.25
4	\$60,750	\$5,063	\$29.23
5	\$71,100	\$5,925	\$34.21
6	\$81,450	\$6,787	\$39.19
7	\$91,825	\$7,652	\$44.18
8	\$102,225	\$8,519	\$49.18
Each additional person, add	\$10,400	\$867	\$5.00

The Wyoming Colorectal Cancer Screening Program & the Breast and Cervical Cancer Early Detection Program use 250% poverty guidelines to determine eligibility. Poverty guidelines are updated annually by the federal government. You can find the current poverty guidelines at <https://aspe.hhs.gov/poverty-guidelines>



# Colorectal & Breast and Cervical Screening Programs Enrollment Form

I am enrolling in:  **Check box**  Breast & Cervical **WBCC** And/Or  Colorectal **WCCSP**

Office use only  
Copy to:

<b>First Name</b>	<b>Initial</b>	<b>Last Name</b>	<b>Maiden Name</b> <small>(if applicable)</small>
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<b>Mailing Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Birth Date</b> / /	<b>Age</b>
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<b>Home Phone</b>	<b>Work Phone</b>	<b>Cell Phone</b>	<b>How did you hear about the program?</b>
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<b>Alternate Contact:</b> Contact person: _____ Relationship: _____ Phone: (____) _____	<input type="checkbox"/> Doctor <input type="checkbox"/> Friends <input type="checkbox"/> Breast & Cervical Program <input type="checkbox"/> Radio <input type="checkbox"/> Family <input type="checkbox"/> Poster <input type="checkbox"/> Community Event <input type="checkbox"/> Television <input type="checkbox"/> Mailing/Flyer <input type="checkbox"/> Free Clinic/CHC <input type="checkbox"/> IHS <input type="checkbox"/> Health Fair <input type="checkbox"/> Other healthcare provider <input type="checkbox"/> Website <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Wyoming Cancer Resource Services (WCRS) <input type="checkbox"/> Newspaper/Magazine <input type="checkbox"/> Other _____
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<b>What race/ethnicity are you? (check all that apply)</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Hawaiian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Male	
	<input type="checkbox"/> Female	

<b>What is your primary language?</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____  <b>Social Security Number: (Optional)</b> ___ - ___ - ____	<b>Name of Health Care Provider (if applicable)</b> <b>Name</b> ----- <b>Phone :</b> (    ) ----- <b>Name of clinic:</b> ----- <b>City:</b> -----
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**Insurance Information** *(The WCCSP serves Wyoming residents that are uninsured and underinsured. Please notify your healthcare provider of any private insurance, they must bill your insurance before they bill the WCCSP.)(The WBCC serves only uninsured residents)*

**Do you currently have private insurance?**    Yes                       No

**Does it cover the cost of a colonoscopy?**    Yes                       No                       Don't Know

**Do you have Medicare?**    No                       Yes                       Part A only?    or                       Part A & B

**Do you have Medicaid?**    No                       Yes

**Current Income** ( list gross before taxes)

Your current monthly household income:-----

How many people live on this income? -----

<b>Office use only:</b> Approved----- Denied----- Date: ----- Staff Notes: ----- ----- ----- StateID# -----	<p style="color: red;"><i>Patient: Sign name -----</i></p> <p style="color: red;"><i>Print Name : -----</i></p> <p style="color: red;"><i>Today's Date : ----- /----- /----- (mm/dd/yyyy)</i></p>
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Consent, Release & Confidentially Statement

*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 Colorectal Screening Program the Centers for Disease Control and Prevention, and others involved in my care to share medical information obtained for the purpose of screening, diagnosis, treatment, and program evaluation.*

*I understand that information received by the Wyoming Breast and Cervical Cancer Early Detection Program or the Colorectal Screening Program will be treated as confidential and that any uses and disclosures will be in accordance with Wyoming Department of Health (WDH) policies. For additional information regarding WDH uses and disclosures of protected health information, visit the Department's HIPAA website.*

**If you are applying for a free colonoscopy**

**Family History**

- Have any family members (parents, brothers, sisters, children) have been told they have colon or rectal cancer or colon polyps?  
Circle one: 0 1 2 3+ Don't Know
- How many of those family members were under the age of 60 when diagnosed with colon cancer or polyps?  
Circle one: 0 1 2 3+ Don't Know

• Have you ever been told by a doctor that you have had any of these conditions? (circle all that apply)  
Cancer of the colon or rectum, Crohn's disease, Familial Adenomatous Polyposis ( FAP ), Hereditary Non Polyposis Colorectal Cancer ( HNPCC), Inflammatory Bowel Disease (IBD) , Ulcerative Colitis.

- Are you currently under a doctor's care for any of the above conditions?  Yes  No  Don't Know

**Personal History** Have you ever had the following tests?

**Fecal Occult Blood Test (FOBT) or FIT Test**  Yes Date \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Don't Know  
If yes, was your test positive or negative?  Positive  Negative  Don't Know

**Colonoscopy**  Yes Date \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Don't Know  
If yes, were there polyps removed?  Yes  No  Don't Know

**I have been a Wyoming resident for at least 1 (one) year immediately prior to submission of this application**  
 YES  NO

**If you are applying for a free mammogram or pap test**

**Eligibility Requirements:** Age/Risk factor, Income (250% of federal poverty level), and **NO** insurance

Do you currently smoke/use tobacco products? **YES NO**

Have you had a hysterectomy? **YES NO**

If so, was your cervix removed?

**YES NO Don't Know**

When was your last pap test? -----

Was it abnormal? **YES NO** **\*\*If yes, see instructions below for required report**

When was your last mammogram? -----

Was it abnormal? **YES NO** **\*\*If yes, see instructions below for required report**

When was your last clinical breast exam? -----

Was it abnormal? **YES NO** **\*\*If yes, see instructions below for required report**

Have you had breast cancer? **YES NO**

If yes, when? -----

**\*\*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**