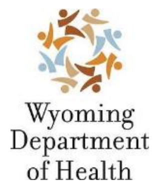

Colorectal and Breast & Cervical Cancer Screening Programs Enrollment Form

Applicant Information

First Name, MI, Last Name:		Date of Birth: Age:
Gender: ☐ Male ☐ Female ☐Transgender Male ☐Transgender Female		Social Security # (if applicable):
Home Phone:	Cell Phone:	Work Phone:
Mailing Address: PO Box: Apt. #: County:		Email address:
City:	State:	ZIP Code:
Alternate Contact/Relationship:		Alternate Contact Person's Phone:

What race/ethnicity are you? (circle all that apply)

American Indian	White	Asian	Unknown
Black/African American	Pacific Islander/Hawaiian	Hispanic/Latino	Other:

What is your primary language? Do you need an interpreter? **YES** **NO**

Have you been a Wyoming resident for at least 1 (one) year? **YES** **NO**

Do you currently smoke/use tobacco products? *This does not affect eligibility.* **YES** **NO**

How many people live in your household?

What is your household's **monthly** gross income (before taxes)?
Be sure to include all income from all members in the household.

How Did You Hear About the Program? (Circle All that Apply)

Health Care Provider	Patient Navigator	Mailing/Flyer
Indian Health Services	Wyoming Cancer Resource Services	Website
Public Health Nurse	Family/Friend	Television/Radio
Free Clinic	Health Fair/ Community Event	Newspaper/Magazine
Other:		

Tell Us About Your Insurance Status

Do you currently have medical insurance? **YES** **NO**

Do you have Medicaid? **YES** **NO**

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

Tell Us About Your Medical Provider

Name of Healthcare Provider:
Name of Healthcare Clinic:

Phone:	City:	State:

Revised 17 May, 2018

Please continue application on next page.

Complete If You Are Applying for a Free Colonoscopy

Have you ever been diagnosed with any of these conditions? Circle all that apply:

Colon or rectal cancer	Crohn's Disease	Familial Adenomatous Polyposis
Ulcerative Colitis	Inflammatory Bowel Disease	Hereditary Non Polyposis Colorectal Cancer

Have you ever had the following screenings?

Fecal Occult Blood Test (FOBT) Fit Test	**NO**	**YES**	Date:	FIT Result:	**Positive**	**Negative**	**Don't know**
Colonoscopy	**NO**	**YES**	Date:	Were polyps removed?			

Have any family members (parents, siblings, children) been told they have colon or rectal cancer or colon polyps?	**YES** **NO** How many?
How many of those family members were under the age of 60 when diagnosed with colon cancer?	

Complete If You Are Applying for a Free Mammogram and/or Pap Test

Have you had a hysterectomy?	**YES**	**NO**	If yes, was your cervix removed?	**YES**	**NO**
Have you had breast cancer?	**YES**	**NO**	If yes, when?		
When was your last Pap test?	Date:		Was it abnormal?	**YES**	**NO**
When was your last mammogram?	Date:		Was it abnormal?	**YES**	**NO**
When was your last clinical breast exam?	Date:		Was it abnormal?	**YES**	**NO**
Have you ever taken hormone therapy?				**YES**	**NO**

Breast Cancer Risk Assessment

Have you been told that you have a known genetic mutation of the BRCA1 or BRCA2 gene?	**YES**	**NO**
Do you have a mother, sister, or daughter who has been diagnosed with premenopausal breast cancer, or who has known genetic mutations of the BRCA1 or BRCA2 gene?	**YES**	**NO**
Do you have a history of radiation to your chest area before age 30?	**YES**	**NO**

Authorization

By signing below, I am certifying that 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. By agreeing to take part in this program, I give my permission to healthcare providers, billing agencies, Wyoming Department of Health, the Centers for Disease Control and Prevention, and others involved in my care to share medical information obtained. The Wyoming Department of Health (WDH) uses information in accordance with State and Federal law and the WDH Notice of Privacy Practices (NoPP). The WDH NoPP can be found on the Wyoming Department of Health's website at www.health.wyo.gov or a copy can be requested by calling 1-800-264-1296.

Patient Signature: Date:

Print Name:

Please submit the application by email, mail or fax:

Mailing Address: **Wyoming Cancer Program**
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002

Fax: 307-777-3765

Email: wdh.cancerservices@wyo.gov

If you have any questions or need help filling out this application, contact the program at 1-800-264-1296 or visit our website: www.health.wyo.gov/publichealth/prevention/cancer.

Office use only:	Approved	Denied	Date:
Staff Notes:			State ID: Ref Loc: