If you have any questions or need help filling out this application, contact the program at 1-800-264-1296.

Applicants: You are applying for financial assistance with the cost of mammograms, Pap tests, or colorectal cancer screenings. By completing this application you are expressing your interest in completing the cancer screenings that your medical provider has recommended for you. **Your eligibility in the program will be decided once the completed application is submitted. Please make sure all sections are completed to the best of your knowledge.**

Providers: If you are completing this application for a client, please include your clinic information below so that the program can reach out with any questions.

Clinic name: _____ **Email address:** _____

Clinic phone: _____ **Clinic fax:** _____

Applications process in 7-10 business days

Colorectal and Breast & Cervical Cancer Screening Program Enrollment Form

Applicant Information

First Name, MI, Last Name:		Date of Birth: Age:
Gender: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male		
Are you a U.S. Citizen? **YES or NO** *This does not affect eligibility and is only used for data purposes.*	Social Security Number (SSN): ***Required*** *if you have a SSN. If you do not have a SSN please mark as N/A.*	
Home Phone Number: Cell Phone Number:	Email address:	
The program may send electronic reminders or other important program updates. Check all ways that you approve the program contacts you. ☐ Text message ☐ Email		
Where do you receive mail? (Include Street Address, P.O. Box, or Apt. #.)		County:
City:	State:	ZIP Code:
REQUIRED: How many dependents (including yourself) live in your household?		
REQUIRED: How much money does everyone living in your household earn combined, before taxes? *Additional information on calculating household income can be found here:* *https://www.healthcare.gov/income-and-household-information/*		$_____ ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐ **Yearly**

What is your race/ethnicity? (circle all that apply)

American Indian	Caucasian/White	Asian	Non-Hispanic/Latino Origin
Black/African American	Pacific Islander/Hawaiian	Hispanic/Latino	Other/Prefer Not to Answer

What is your primary language? Would you like an interpreter? **YES or NO**

Do you currently have private medical insurance? **YES or NO** *If yes, please complete the following question and include a copy of your insurance card with this application. Contact information on page 2.*

Insurance Company Name: Policy Number:
Policy Holder Full Name: Policy Holder Date of Birth:
Group Number: Policy Start Date (*if known*):

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

Do you have Medicare? **YES** if yes, circle one: Part A only Part A&B Part B only **NO**

Are you currently eligible for the Federal Medicare Program? **YES or NO**

Name of your healthcare provider:

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

If you use tobacco products, you will be referred to a Quitline Coach who will contact you within approximately thirty (30) days.

☐ Check this box if you do **not** want to be contacted by a Quitline Coach.

Wyoming Quitline: 1.800.QUIT.NOW / quitwyo.org

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

Are you currently having any issues with your breast or cervix? **YES or NO** *If yes, please explain:*

Have you ever had the following screenings?

Pap test	**YES or NO**	If yes, when?	Was it **normal** or **abnormal**? (circle one)
HPV test	**YES or NO**	If yes, when?	Was it **positive** or **negative**? (circle one)
Mammogram	**YES or NO**	If yes, when?	Was it **normal** or **abnormal**? (circle one)
Clinical Breast exam	**YES or NO**	If yes, when?	Was it **normal** or **abnormal**? (circle one)

Have you had a double mastectomy? **YES or NO** Have you had a hysterectomy? **YES or NO**

Have you had breast cancer? **PAST or PRESENT or NO**

Have you ever taken hormone therapy (not including birth control)? **YES or NO**

Have you been told that you have a known genetic mutation of the BRCA1 or BRCA2 gene? **YES or 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 or NO**

Do you have a history of radiation to your chest area before age 30? **YES or NO**

Complete ONLY if You Are Applying for a Free Colorectal Cancer Screening

Must be over age 45 to be eligible

Have you been a resident of Wyoming for at least 1 year? **YES or NO**

If no, what month did you move to Wyoming? _____

(Please note that for colorectal cancer screenings, your application may be held until you have reached 1 year residency status.)

Are you currently having any issues with your bowels? **YES or NO** *If yes, please explain:*

Have you had a colonoscopy in the last 10 years? **YES or NO** *If yes, when?* _____

If you have had a colonoscopy, were polyps removed? **YES or NO or Don't Know**

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. 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. I give my permission for the program to leave messages on my voicemail, answering machine, with my family members, or via electronic notifications such as text messaging or email. 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 health.wyo.gov or a copy can be requested by calling 1-800-264-1296.

Patient Signature: Date:

Print Name:

Please submit this application by email, mail or fax:

Mailing Address: **Wyoming Cancer Program**
122 West 25th Street, 3rd Floor West
Cheyenne, WY 82002

Fax: (307) 777-3765
Email: wdh.cancerservices@wyo.gov

If you have insurance, please submit a copy, scan, or photograph of your insurance card by email, mail, or fax. If you need additional options, please contact the program for instructions.

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