

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 fax: Clinic phone: ___ 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: ☐ Female Gender: ☐ Male ☐ Transgender Female ☐ Transgender Male Are you a U.S. Citizen? YES Social Security Number (SSN): This does not affect eligibility and is only used for data purposes. Required if you have a SSN. If you do not have a SSN please mark as N/A. Home Phone Number: Email address: Cell Phone Number: 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: ZIP Code: City: State: **REQUIRED:** How many dependents (including yourself) live in your household? **REQUIRED:** How much money does everyone living in your household earn combined, before taxes? ☐ Weekly ☐ Bi-Weekly Additional information on calculating household income can be found here: \square Monthly \square Yearly https://www.healthcare.gov/income-and-household-information/ What is your race/ethnicity? (circle all that apply) Asian American Indian Caucasian/White 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 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:

YES

NO

Part A&B

Policy Holder Full Name:

Do you have Medicaid?

Do you have Medicare? YES if yes, circle one: Part A only

Are you currently eligible for the Federal Medicare Program?

Group Number:

NO

Policy Holder Date of Birth: Policy Start Date (*if known*):

Part B only

NO

YES

•	care provider:											
Do you currently sme	oke/use tobacco j	products? This d	loes not affect e	eligibil	lity.			YI	ES	or N	Ю	
If you use tobacco pr	•	be referred to a	a Quitline C	Coacl	h who	wil	ll con	ntact y	you v	vithin		
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Are you currently ha												
Are you currently ha	ville ally issues v	with your breas	t of cervix:	. 1	ES (01 1	110	ij ye	s, pu	еизе елр	<i>н</i> ин.	
Have you ever had	the following sci	reenings?										
Pap test	YES or No	O If yes, w	hen?		Wa	as it	norn	nal or	r <mark>ab</mark> n	ormal?	(circle	e one)
HPV test	YES or No	O If yes, w	hen?		Wa	as it	posit	tive o	r ne g	gative?	(circle	one)
Mammogram	YES or No	O If yes, w	hen?		Wa	as it	norn	nal or	r abn	ormal?	(circle	e one)
Clinical Breast exam	YES or No	O If yes, w	hen?		Wa	as it	norn	nal or	r abn	ormal?	(circle	e one)
Have you had a doub	ole mastectomy?	YES or NO) Have	you l	nad a	hyst	terect	tomy?	?	YES	or or	NO
Have you had breast	cancer?					PA	ST	or	PRE	ESENT	or	NO
Have you ever taken	hormone therapy	y (not including	g birth cont	rol)?	1					YES	or	NO
Have you been told t						1 oı	r BR	CA2	gene	? YE \$	or	NO
Do you have a mother	•										5 or	NO
breast cancer, or who	-		-		_		-					
Do you have a histor	y of radiation to	your chest area	a before age	e 30?	1					YES	or or	NO
Complete (DNLY if You	Are Applyir	ng for a F	ree	Colo	orec	etal (Cano	cer S	Screen	ing	
		Must be over	_									
Have you been a resi	dent of Wyomin	g for at least 1	vear?							VES	or	NO
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If no, what month die	d you move to W	yoming?										
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