# Eligibility for the Breast & Cervical, and Colorectal Cancer Screening Programs - ***Avoiding Application Delays***

May 2023 - Wyoming Cancer Program Listening Session

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# Objectives

- Understand the eligibility criteria for the Breast & Cervical Cancer Screening Program (WBCCEDP) & Colorectal Cancer Screening Program (WCCSP)
- Realize that missing data on the application may cause a delayed approval which can cause a delayed screening
- Relate knowledge to parts of the most current Wyoming Cancer Program (WCP) application

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# Eligibility Guidelines for Breast & Cervical Cancer Screenings (WBCCEDP) and Colorectal Cancer Screenings (WCCSP)

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# WBCCEDP Eligibility Guidelines

- Available on the website for WBCCEDP

- Eligibility determined through 3 categories first:
  - Gender is female or transgender persons
  - Income must be at or below 250% of FPL for the people in your household that you count in federal income tax returns
  - Patients must be uninsured or underinsured (have an out of pocket cost required by their health insurance plan that they cannot afford). This excludes certain Medicaid programs and Medicare Part B.

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# WBCCEDP Eligibility Guidelines

- Wyoming Breast & Cervical Cancer Early Detection Program has extra eligibility requirements due to age:

- Breast cancer screenings eligibility criteria
  - 18-39 - Symptomatic, or, asymptomatic and high risk
  - 40-64 - No additional requirements
  - 65+ Applicants must not have Medicare Part B

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# WBCCEDP Eligibility Guidelines

- Cervical cancer screenings eligibility criteria
  - 21-29 - Symptomatic, or, asymptomatic and have not had a pap test in 3 years
  - 30-64 - Symptomatic, or, asymptomatic and have not had a pap test in 3 years, or, have not had co-testing with a pap test & HPV test in 5 years
  - 65+ Applicants must not have Medicare Part B

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# WCCSP Screening Eligibility Guidelines

- Available on the website for WCCSP

- Eligibility determined through 4 categories first:
  - Resident of Wyoming at least 1 year
  - Aged 45+
  - Income must be at or below 250% of FPL for the people in your household you count in federal income tax returns
  - Patients must be uninsured or underinsured (Have an out of pocket cost required by their health insurance plan that they cannot afford).

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# An overview of the Application Process

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# Where to get screening applications?


Please don't use old applications

Applications do get updated every so often. Only download what you need that month

- health.wyo.gov/cancer/program-applications/ houses our English and Spanish applications. Download as needed.

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# Applications Fields

- Please complete all fields on the application or indicate if the information is truly unknown. They help us determine eligibility, assist with easier billing, for CDC data requirements and to assist with case management work

- Any incomplete application will not be processed. Missing data could cause your patient's application to go into pending status

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# Applications Fields

- The most current application can be found on our website
- One application per client - duplicates only slow down the processing time for everyone
- Applications can take up to 10-14 business days to process, check the Medicaid Portal for information on approval status

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# Application - Page 1 of 2

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

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**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: *Drivers License* | 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**

*Revised July 01, 2021* **Page 1 of 2**

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# Application - Page 2 of 2

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:<br>Ref Loc: |



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# Application Form - Let’s take a deeper look at the sections

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# Information for Applicants

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.**

- Please let the patients know who we are, how they can reach us, and an overview of what we cover.

# Provider Information

**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:** _____

- Keeps us up to date with the main person who we can contact for questions, and the main contact who should subscribe to our newsletter from this link.

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# Demographics Page

## Colorectal and Breast & Cervical Cancer Screening Program Enrollment Form

### Applicant Information

First Name, MI, Last Name: *Driviers License*

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:

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# Income Section

| | |
|---|---|
| **REQUIRED:** How many dependents (including yourself) live in your household? | |
| **REQUIRED:** How much money does everyone living in your household earn combined, before taxes?<br>*Additional information on calculating household income can be found here:*<br>*https://www.healthcare.gov/income-and-household-information/* | $ _____<br>☐ **Weekly** ☐ **Bi-Weekly**<br>☐ **Monthly** ☐ **Yearly** |

- Missing income will cause an application to enter pending status. Please fill out accurately.

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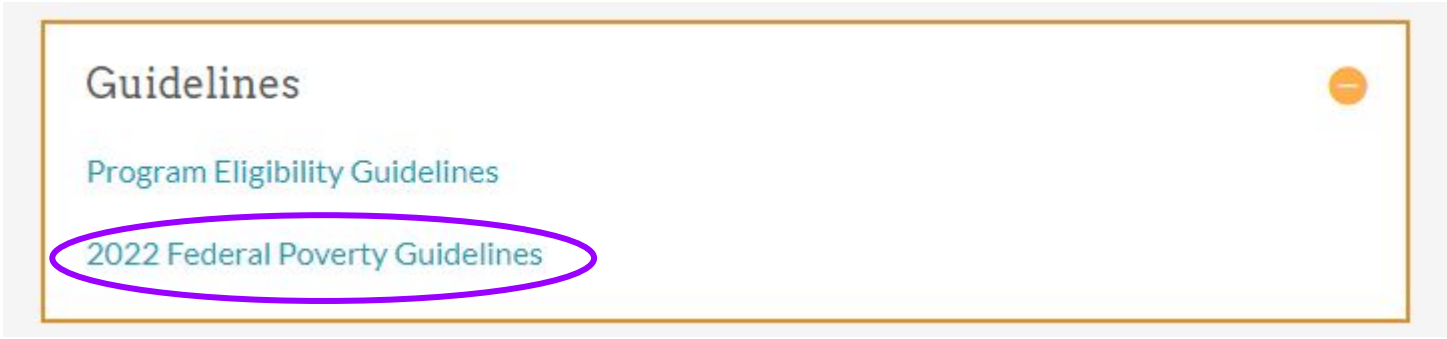
# FPL information on the WCP website


- Please download our FPL guidance document that illustrates the WCP income guidelines 250% of FPL

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# WCP INCOME GUIDELINES

(Based on 250% of federal poverty guidelines)
Maximum Gross Income
(before taxes removed) (updated yearly)

(Effective 2/1/2022 until 6/30/2023)

| FAMILY SIZE: | YEARLY INCOME | MONTHLY INCOME | HOURLY WAGE |
|---|---|---|---|
| 1 | $33,975 | $2,831 | $16.33 |
| 2 | $45,775 | $3,815 | $22.01 |
| 3 | $57,575 | $4,798 | $27.68 |
| 4 | $69,375 | $5,781 | $33.35 |
| 5 | $81,175 | $6,795 | $39.03 |
| 6 | $92,975 | $7,748 | $44.70 |
| 7 | $104,775 | $8,731 | $50.37 |
| 8 | $116,575 | $9,715 | $56.05 |
| Each additional person add | $4,720 | $393 | $2.27 |

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# Insurance Section

| |
|---|
| 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** |

- CDC requires us to be a payor of last resort, so insurance verification is important
- Some Medicaid programs are ineligible for WBCCEDP
- Medicare Part B patients are ineligible for WBCCEDP

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# Smoking Section

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**

- CDC requires us to assess smoking status and to collaborate with the Tobacco Cessation program. As such, we ask for smoking status and refer clients to National Jewish to assist with cessation activities.

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# Prior Pap/Prior Mam & Risk Factors

- As a part of determining eligibility and paying for screenings we need the date of the prior pap test and the prior mammogram (before the period the application was submitted for)
- We want the provider to determine whether a patient is at High Risk for breast cancer and/or cervical cancer
- We actively assist those patients in higher risk groups so we need the dates of the prior pap test & prior mammogram
- CDC guidelines determine what we can and cannot do

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# Prior Pap/Prior Mam & Risk Factors

| 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** |

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# Colorectal Cancer Screening Section

## 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**

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# Authorization - Key Phrases

- ***True Information*** - " ...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."

- ***Data Sharing is okay*** - "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."

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# Authorization

## 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: | |

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# Submission

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.

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# How to submit correctly and what to expect next?

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# Submission Guidelines

- Only one application per client per enrollment period is required
- Always submit an application (even if ineligible for WBCCEDP) to see if additional resources such as PNO are available
- Online applications are preferred to avoid misreading handwritten applications, reducing clinic printing budgets and ensuring data points do not get missed
- Please allow 10-14 business days before contacting the program

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# Submission Guidelines

- Providers with access to the Wyoming Medicaid provider portal can check their approval status at any time by searching for your client

*(If you cannot locate your patient, they may have been denied, they may be waiting for referral to additional resources such as Patient Navigation Only (PNO), or their application is pending due to missing data. No matter where they are in the process, they are not eligible for WCP paid screenings until they go live in the Medicaid system.)*

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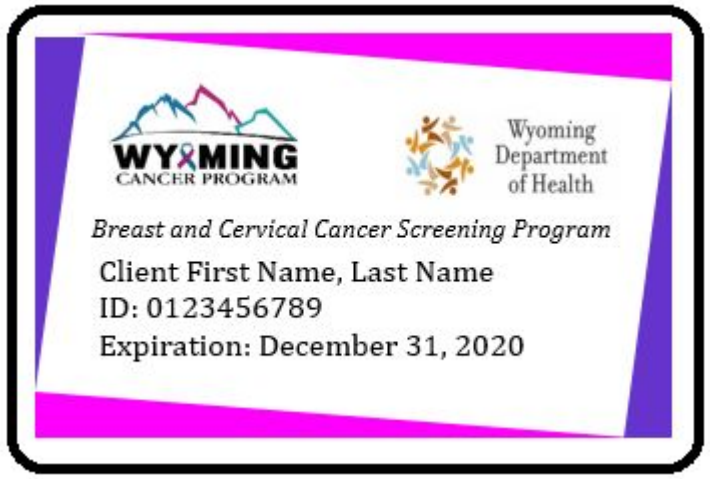
# Application Approval Process




- Patients should be on the lookout for a letter with an ID card and a phone call if they are approved.

- You can check if your patients are approved on the Medicaid Portal (the program details and their expiration will be visible).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# Newsletter &
# Provider Listening Sessions

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# June Provider Listening Session

No registration required.

The next session is on ***"Cancer Treatment Referrals"*** presented by Program Nurse Tanya Riekens. She will share the referral process for clients diagnosed with cancer, the data we need from providers, and the importance of notifying the WCP of a cancer diagnosis.

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# June Provider Listening Session

WCP Screening Program Updates & Listening Session

***“Cancer Treatment Referrals”***

Tuesday, June 20 · 10:00 – 11:00 am

Google Meet joining info: Video Call Link

Or dial: (US) +1 267-393-4324 PIN: 467 030 417#

More phone numbers can be found here.

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# Wyoming Cancer Program Contacts

Unit Manager: Star Jones
Screening Program Supervisor: Mark Kelly
Enrollment and Records Specialist: Nicole Motter
Administrative Assistant: Allison Groendal
Program Nurses:  Val Knepp & Tanya Riekens

*Thank You!*


**Subscribe to receive news from the WCP from this link**

1-800-264-1296
wdh.cancerservices@wyo.gov
health.wyo.gov/cancer

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