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| **Wyoming Cancer Program Enrollment Form** |

**Why do we ask for this information?** You are applying for financial assistance with the cost of mammograms, Pap tests, or colorectal cancer screenings. We ask about income and other information to determine what coverage you qualify for. **Complete all sections to the best of your knowledge.**

**What happens next?** Send your complete, signed application to the contact information at the bottom of page 2. The program will notify you by mail of the status of your application. If your application is missing information to determine eligibility, the program may contact you by phone to gather the necessary information. Please note that applications may take up to 21 business days to process, but processing times may vary due to high volume.

**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Clinic phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Clinic fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **\*Important Note\* Applications process in 14 to 21 business days**  ***(Application processing times may vary due to high volume)*** |

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| **Applicant Information** | | | | |
| First Name, MI, Last Name *(Name as it appears on government-issued ID)*: | | | Date of Birth:  (MM/DD/YYYY) | |
| Gender: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male  *Individuals whose gender identity differs from the sex assigned at birth are still at risk for developing cancer. It is important to receive your cancer screenings if you still have a particular body part or organ.* | | | | |
| 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.* | | |
| Telephone Number: | | | | |
| Where do you receive mail? (Include Street Address, P.O. Box, or Apt. #.) | | | County: | |
| City: | State: | | ZIP Code: | |
| What is your ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin | | | | |
| What is your race:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | ☐ American Indian | ☐ Asian | ☐ Black/African American | | ☐ Eskimo | | ☐ Native Hawaiian | ☐ Pacific Islander | ☐ White | ☐ Other/Unknown: \_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| What is your preferred language? Would you like an interpreter? | | | | **YES or NO** |
| Do you currently have private medical insurance? | | | | **YES or NO** |
| Do you have Medicare Part B? | | | | **YES or NO** |
| Do you currently smoke/use tobacco products? *This does not affect eligibility.* | | | | **YES or NO** |
| **Income Information** | | | | |
| How many dependents (including yourself) live in your household? \_\_\_\_\_ | | | | |
| What is the household income total, before taxes? $\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Monthly ☐Yearly | | | | |
| *Not sure who to count in your household? Additional information on calculating household income can be found here:* [*https://www.healthcare.gov/income-and-household-information/*](about:blank) | | | | |

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| **If You Are Applying for a Free Mammogram and/or Pap Test, Complete This Section**  *Individuals whose gender identity differs from the sex assigned at birth are still at risk for developing cancer. It is important to receive your cancer screenings if you still have a particular body part or organ. The following questions will help determine if you meet certain screening criteria.* | | | |
| Are you currently having any issues with your breasts or cervix? **YES or NO** *If yes, what symptoms are you having?* | | | |
| Have you had a Pap test in the last 3 years or a Pap test with an HPV test in the last 5 years? **YES or NO** | | | |
| If you have had a Pap test or a Pap test with an HPV test, when was it? | | | |
| What were the results of your Pap test? **Normal Abnormal Other:** | | | |
| What were the results of your HPV test? **Positive Negative Other:** | | | |
| Was this your first Pap test? **YES or NO** | | | |
| Prior to the Pap listed above, was the last time you had a Pap more than 10 years ago? **YES or NO** | | | |
| Have you had a mammogram in the last 2 years? **YES or NO** | | | |
| If you have had a mammogram, when was it? | | | |
| Have you had a double mastectomy? | **YES or NO** |  |  |
| Have you had a total hysterectomy?  (A total hysterectomy removes the whole uterus and cervix) | **YES or NO** | Was this due to cervical cancer? | **YES or NO** |
| **Is there anything else you would like us to know about your need for a mammogram or Pap test?** | | | |

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| **If You Are Applying for a Free Colorectal Cancer Screening, Complete This Section**  **Must be over age 45 to be eligible** |

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| Have you lived in 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, what symptoms are you having?* | |
| Do you have any family history of colon cancer (mother, father, sibling)? **YES or NO** | |
| 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** | |
| **Is there anything else you would like us to know about your need for a Colorectal Cancer Screening?** | |

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| **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, the 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 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](about:blank) 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** Fax: **1-307-777-3765**

**122 West 25th Street, 3rd Floor West** Email:[**wdh.cancerservices@wyo.gov**](about:blank)

**Cheyenne, WY 82002**

**Applications process in 14 to 21 business days**

***(Application processing times may vary due to high volume)***

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| **Office use only:** | Approved | Denied | Date: |
| Staff Notes: | | | WCRS: |