Office use only:	Approved	Denied	Date:
Staff Notes:			Enrollment Site:

Wyoming Cancer Program Enrollment Form

Applications typically process in 14 to 21 business days

Patient Clinical, Screening, and Risk Assessment Information

To be Completed by Healthcare Provider Staff or Healthcare Facility

If a section does not apply to the patient or the facility, please mark it 'N/A' or cross it out.

Clinic Name:	Clinic Email:
Clinic Phone:	Clinic Fax:
If the WCP has questions about this application, who do we contact at the clinic?	
Patient Name:	Patient DOB:

Cervical Cancer Screening History

Is this the patient's first ever Pap test?	**YES** ☐ **NO** ☐	**Screening(s) Ordered:**
Has it been more than 10 years since their last Pap test?	**YES** ☐ **NO** ☐	☐ Pelvic exam ☐ Pap test ☐ Pap test with HPV test ☐ HPV test ☐ Colposcopy ☐ Other: _____
When was the patient's most recent Pap test? (MM/YY):		
What were the results of the patient's most recent Pap test?		
Has the patient ever had an HPV test?	**YES** ☐ **NO** ☐	
When was the patient's most recent HPV test? (MM/YY):		
What were the results of the patient's HPV test?		
Has the patient had a total hysterectomy?	**YES** ☐ **NO** ☐	
If **YES**, was this due to cervical cancer?	**YES** ☐ **NO** ☐	
Do you consider the patient high risk for cervical cancer?	**YES** ☐ **NO** ☐	

If the patient is experiencing any issues with their cervix, please list their symptoms/clinical presentation:

Breast Cancer Screening History

Has the patient had a double mastectomy?	**YES** ☐ **NO** ☐	**Screening(s) Ordered:**
Has the patient ever taken hormone replacement therapy?	**YES** ☐ **NO** ☐	☐ CBE ☐ Mammogram
Has the patient ever had a mammogram?	**YES** ☐ **NO** ☐	☐ Diagnostic Mammogram
When was the patient's most recent mammogram? (MM/YY):		☐ Ultrasound ☐ Breast MRI
What were the results of the patient's last mammogram?		☐ Other: _____
Do you consider the patient high risk for breast cancer?	**YES** ☐ **NO** ☐	

If the patient is experiencing any issues with their breast, please list their symptoms/clinical presentation:

Colorectal Cancer Screening History

Has the patient had a colonoscopy in the last 10 years?	**YES** ☐ **NO** ☐	**Screening(s) Ordered:**
When was the patient's most recent colonoscopy? (MM/YY):		***Must be age 45+ to be eligible***
Did the patient have polyps removed?	**YES** ☐ **NO** ☐	☐ FIT Kit
Do you consider the patient high risk for colon cancer?	**YES** ☐ **NO** ☐	☐ Cologuard ☐ Colonoscopy

If the is patient experiencing any issues with their bowels, please list their symptoms/clinical presentation:

- The Wyoming Cancer Program follows USPSTF guidelines for all average risk, preventive screenings. Patients who are considered high risk may be eligible for additional services.
- Providers are encouraged to provide additional documentation such as pathology reports, radiology reports, or clinical notes if you believe it to be helpful in determining eligibility.
- **Refer to the WCP Provider Manual for more information on the screening program processes and procedures.**

Applicant Information

To be Completed by Applicant or Medical Representative

All fields in the applicant section are required, incomplete applications will not be processed.

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

Are you a U.S. citizen? **YES** ☐ **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:	Email Address:

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** ☐	**NO** ☐
Do you currently have private medical insurance?	**YES** ☐	**NO** ☐
Do you have Medicaid?	**YES** ☐	**NO** ☐
Do you currently smoke/use tobacco products? *This does not affect eligibility.*	**YES** ☐	**NO** ☐
Have you lived in Wyoming for at least 1 year?	**YES** ☐	**NO** ☐

Total number of household members (including yourself): _____

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/

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 (WDH), 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 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 WDH's website at health.wyo.gov or a copy can be requested by calling 1-800-264-1296.

Patient Signature: **Date:**

Print Name:

***The Wyoming Cancer Program is not healthcare insurance coverage; it is limited coverage for breast, cervical, and colorectal cancer screenings for qualified patients.**

Please submit this completed application by email, mail, or fax:

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

Fax: **1-307-777-3765**
Email: **wdh.cancerservices@wyo.gov**

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