



BCC Program

Florida Breast and Cervical Cancer Early Detection Program

FREE mammogram and Pap smear

Women 50 to 64 years old – low income – no insurance

(727) 824-6917



ENROLLMENT INSTRUCTIONS:

Complete and return the entire original packet - any blanks will delay your appointment!

*****Keep the yellow copy of the “Annual Application Agreement”. *****

We have several Health Departments that are utilized for the Clinical Breast Exams (CBE) and Pap Tests. If you do not have a prescription, a CBE must be completed before your mammogram is scheduled. Pap smears are done if you have not had a hysterectomy and you are eligible. Paps are done every 3 to 5 years unless there is a current problem.



Please indicate your preference for day of the week and time of day for your appointments on the Appointment Scheduling Page.

BCC must schedule all of your appointments



Send these pages back in the enclosed pre-paid envelope and we will schedule your appointments and send you an authorization to take with you. *Please keep in mind we are currently processing a high volume of applications. Please do not call to inquire on the status of your application. We will contact you when we are able to schedule your appointment.*

****If you have any further questions, please call Tina Walker or Lisa Field;**

(727) 824-6917

Make a copy for your own records, if you wish.

If you misplaced the attached return envelope, please mail application to:

Breast and Cervical Cancer Screening Program

Florida Department of Health in Pinellas County

PO Box 13549

Saint Petersburg, FL 33733



FLORIDA BREAST AND CERVICAL CANCER
EARLY DETECTION PROGRAM
BCC PROGRAM



Patient Information Form

Women 50 to 64 years old – low income – no insurance
FREE mammogram and Pap smear
Phone (727) 824-6917

Legal Last Name: _____ Legal First Name: _____ MI: _____
(Per state issued ID) (Per state issued ID)
Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
Month Day Year
Address: _____ Lot/Apt: _____
City: _____ FL, Zip: _____ Best time to call: _____
Home Phone: _____ Work or Cell Phone: _____ Sex: Female

Marital Status: Single Married Divorced Separated Widowed

Race: White Black Pacific Islander Asian American Indian

Height (In): _____ Weight (lbs.): _____

Do you have a history of high blood pressure? _____

Primary Language: (If other than English) Spanish Other (specify) _____

Are you Hispanic or Latina? Yes No

How did you find out about our program? Local ACS Brochure CHD Community Family/ Friend Internet Dr Office
 Newspaper Postcard FQHC Reach and Connect

I, _____ give my permission for the Florida Breast & Cervical
Cancer Early Detection Program to identify me as a client of their program when they call me at
() _____.

I also give permission for the Breast & Cervical Cancer Screening Program to leave detailed
messages at the above phone number for me if needed.

Date: _____

Signed _____

This is required information and must be completed in full. If you have questions, please feel free to call us.

Applicant Declaration of Income

Check box that applies to family size. Yearly gross income (**before taxes**) must be equal to or less than amount listed for the family size that you check off in the box below.

Applicant Family Size	DOH Scale Yearly income (updated 8/11/15)
1	23,540
2	31,860
3	40,180
4	48,500
5	56,820



List names, ages, monthly income, and relationship to you for everyone (including yourself) in your household:
Ex: 1. Jane Doe- 54-self- \$1,800/ month

1.
2.
3.
4.
5.

I do not have Medicare part A & B, nor Medicaid, nor private health insurance.

If you have Medicaid "Share of Cost", indicate the amount of your share _____.

I authorize the use and disclosure of general medical information for treatment, payment, data analysis and services.

I authorize the fax of patient information.

If I do not follow the BCC guidelines I will be responsible for my medical bills.

Are you enrolled in the County Health Plan for Primary Care Services? Yes No

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the department of health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information. I further understand that if diagnostic procedures are required for my care, I will be expected to provide more information regarding my income.

Date: _____ Client Signature: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS- ANY BLANKS WILL



DELAY YOUR APPOINTMENT

Name of someone who can always reach you: (Last, First) _____

Relationship with you _____

Phone number of the person who can always reach you: _____

****This number should not be the same as your home or work****

How often do you consume Tobacco? Daily some days Not at all Decline to answer

Have you had breast cancer? No Yes

Have you had ***invasive*** cervical cancer? No Yes

If yes, please explain _____

Has anyone in your family had breast cancer? No Yes

If "yes" circle one Mother/sister/daughter/other _____

Have you had a mammogram before? No Yes If yes, prior mammogram date _____ / _____
Month Year

Where did you have your last mammogram? _____
(Name of Facility)

Have you had a hysterectomy? **(Have you had surgery to remove your uterus & cervix?)**

No Yes if yes, date of surgery _____ / _____
Month Year

****If yes, BCCP will not provide a pap smear, per grant guidelines****

Have you had a pap test before? No Yes if yes, prior Pap test date _____ / _____
Month Year

If eligible, are you interested in having a Pap test done? No Yes

Do you have breast implants? No Yes

Are you having any **breast** problems? No Yes

If yes, please list what breast problems you are having: (Please be as specific as possible)



Please Note: The program will make every attempt to schedule you at the facility closest to your home at a time that matches your preferences. However, due to limited availability we may not be able to accommodate your requests. We appreciate your cooperation and understanding in this matter. Due to the volume of clients waiting for services missed appointments will not be automatically rescheduled. Please call a minimum of 24 hours in advance if you are not able to keep your appointment.

Appointment Scheduling

Check the box below and indicate your time and day of preference. We will try to accommodate you; however, the facilities have set scheduling hours.

Time Preference

Anytime Morning Afternoon

Day of the week preference

Anyday Monday Tuesday Wednesday Thursday Friday

Do you have reliable transportation to get to your appointment? If no, how do you plan to get to your appointments?

Yes No

If no, please explain:

Please advise of any dates that you are not available. _____

You must be committed to making it to your appointments. If not, please do not apply. We have many women who need these appointments and “no shows” reduce our ability to serve those who are committed. We thank you for your cooperation.

***If you have a prescription for a mammogram you must send it in with this application.**

