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: _______/______/_______
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

When was the last time you had any type of health insurance? ________________________________

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: _______________________

Revised Date March 2017
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.

<table>
<thead>
<tr>
<th>Applicant Family Size</th>
<th>DOH Scale</th>
<th>Yearly income (updated 3/17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>$24,119</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>$32,479</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>$40,839</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>$49,199</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>$57,559</td>
</tr>
</tbody>
</table>

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” or Medically Needy, 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 have catastrophic insurance coverage 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: __________________________________________

Revised Date March 2017
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.