Florida Breast and Cervical Cancer Early Detection Program
FREE mammogram and Pap smear
Women 50 to 64 years old – low income – no insurance
Free or low -cost mammogram and Pap test
(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. Pap testing is recommended 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 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. Keep in mind we process a high volume of applications. Please give us 3 weeks before calling to inquire on the status of your application. We will contact you with your scheduled appointment.

**If you have any further questions please contact;
Michelle M. Black
(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

Revised: April 28, 2019
FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM

BCC PROGRAM

Patient Information Form
Women 50 to 64 years old – low income – no insurance
Free or low-cost 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: Divorced Married Separated Single Widowed

Race: (✓ all that apply) □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ Unknown □ White

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

Are you Hispanic or Latina? □ Yes □ No

How did you find out about our program?

☐ ACS ☐ Billboards ☐ Brochures
☐ Bus wraps/bench/placards ☐ CHD ☐ Community
☐ Educational Session ☐ Family/Friend ☐ FQHC
☐ In-reach ☐ Internet ☐ Medical Office
☐ Newspaper ☐ Outreach ☐ Postcard
☐ Radio ☐ Social Media ☐ Television

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. I also give permission for the Breast & Cervical Cancer Screening Program to leave detailed messages at this phone number for me if needed. (__) ____________.

Signed ____________________________ Date: ____________

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

Do you have a history of: (check all that apply)?
☐ Pre-diabetic  ☐ Diabetic
☐ High blood pressure  ☐ High blood cholesterol  ☐ None

Do you?
☐ Exercise 5x weekly  ☐ Eat 5 servings of fruits/vegetables daily

How often do you consume Tobacco or other smoking devices (i.e. vaping, e cigarette)?
☐ Daily  ☐ some days  ☐ Not at all  ☐ Decline to answer

Height (inches): _________  Weight (pounds): _________

Breast Risk Information and History

Have you had breast cancer?  ☐ No  ☐ Yes
Has anyone in your family had breast cancer?  ☐ No  ☐ Yes
If “yes” circle one  Mother/sister/daughter/other _______________________________________

Risk for Breast Cancer:  Average ☐ High/Increased ☐ Not Assessed ☐ Unknown ☐

Have you had a mammogram before?  ☐ No  ☐ Yes  If yes, prior mammogram date________/____
Name of Facility where you had last mammogram? ____________________________________________

Do you have breast implants?  ☐ No  ☐ Yes

Are you having any breast symptoms?  ☐ No  ☐ Yes
If yes, please list what breast symptoms you are having: (Please be as specific as possible)
______________________________________________  ______________________________________

Cervical Cancer Risk Information and History

Have you had cervical cancer?  ☐ No  ☐ Yes

Have you had a hysterectomy?  (Have you had surgery to remove your uterus & cervix?)
☐ No  ☐* Yes  date of surgery ________/_______  *If yes, BCCP will not provide a pap smear

Have you had a pap test before?  ☐ No  ☐ Yes  if yes, prior Pap test date ________/_______
If eligible, are you interested in having a Pap test done?  ☐ No  ☐ Yes
Are you having any cervical issues?  ☐ No  ☐* Yes  *List symptoms

Revised  April 29, 2019
Risk for Cervical Cancer: Average ☐ High/Increased ☐ Not Assessed ☐ Unknown ☐

**Applicant Declaration of Income**

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

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**Check box that applies to family size.** Yearly net income 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 Monthly income (updated 2018)</th>
<th>Applicant Family Size</th>
<th>DOH Scale Yearly income (updated 2018)</th>
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<tr>
<td>1</td>
<td>$2,023</td>
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<td>$2,743</td>
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<td>4</td>
<td>$4,183</td>
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<td>$4,903</td>
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<td>$58,840</td>
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When was the last time you had any type of health insurance? _______________________________________

Do you have Medicare part A & B, or private health insurance?  Yes  No

Do you have Medicaid, Medicaid “Share of Cost” or Medically Needy?  Yes  No
If Share of Cost indicate the amount of your share ________________.

Do you have catastrophic insurance coverage?  Yes  No

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

I authorize the use and disclosure of general medical information for treatment, payment, data analysis and services.  Yes  No

I authorize the fax of patient information.  Yes  No

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

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.

Revised  April 29, 2019
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 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. ____________________________________

Please be committed to keeping your appointments. If not, please do not apply. We have many women who need this service and missed appointments reduce our ability to serve those who are in need. We thank you for your cooperation.
PLEASE ANSWER ALL QUESTIONS ON THIS APPLICATION

ANY UNANSWERED QUESTIONS MAY DELAY YOUR SERVICES

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**

*A prescription is required before your mammogram can be scheduled. Please check below*

If you have a prescription for a mammogram, please mail it in with this application. ______

If you do not have a prescription, a clinical breast exam (CBE) will be scheduled. ______

Complete **Annual Applicant Agreement** form