**BCCHP ENROLLMENT FORM**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please Print **New to BCCHP?**  **Yes  No Authorization #** | | | | | | | | | |
| **Last Name** | | | **First Name** | | | **MI** | | **Authorized for:**  **CBE**  **Pelvic**  **Pap**  **Mammogram** | |
| **Gender**:  **Female  Male  Transman  Transwoman**  **Genderqueer  Gender Non-Binary  Agender  \_\_\_\_\_\_\_**  **Services of interest:  Breast  Cervical** | | | | | | | | **Prime Contractor** | **Date** |
| **Date of Birth** | **Last 4 Digits SSN (Optional)** | | | | | | | **Clinic / Screening Site** | |
| **Address** | | | | | | | | **Appointment**  **Date:** **Time:** | |
| **City** | **State** | | | **Zip Code** | **County** | | | **Clinic Chart #** | |
| **Telephone Numbers: OK to leave a message?  Yes  No**   **Best time to call:  a.m.  p.m.**  **Home:       Cell:       Work:       Alternate:** | | | | | | | | | |
| **Program Eligibility: must be completed annually** | | | | | | | | | |
| **Household income before taxes?** **$** **Per  Month**  **Year** How **many people live on this income?** | | | | | | | | | |
| **Checked eligibility for Apple Health  Yes  No (reason**      **) Date:**  **Eligible for Apple Health  Yes  No Enrolled on Apple Health  Yes  No Date:** | | | | | | | | | |
| **Do you have?** (select all that apply)  **No Health Insurance & Not Eligible for Apple Health (attach denial if available)**  **Medicare Part B  Apple Health, Medicaid, Provider One #**  **Insurance Name of company:** **Deductible: $****Policy/ID #:** | | | | | | | | | |
| **Do you have any problems with your breasts?  Yes  No If yes, what problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | |
| **Primary Language?** (check all that apply, circle prefer) **English  Spanish  Vietnamese  Chinese  Korean**  **Cambodian  Russian  Other (specify:****) Do you need an interpreter?  Yes  No** | | | | | | | | | |
| **What race do you think of yourself?** (Mark one or more)  **Asian  Black or African American**  **American Indian or Alaska Native (specify tribe:      )**  **White or Caucasian  Native Hawaiian or other Pacific Islander (specify:** **)**   **Unknown** | | | | | | | | | |
| **Do you consider yourself Latina/Latino or Hispanic?  Yes  No** | | | | | | | | | |
| **What is the highest grade of school you have completed?** (number of school years) | | | | | | | | | |
| **If you are NEW to BCCHP, how did you learn about this program?** (select only one) | | | | | | | | | |
| **Clinic**  **Community organization**  **Employer**  **Outreach worker** | | **Friend or relative**  **Internet search – BCCHP website**  **Mailing**  **Poster, Flyer or Brochure** | | | | | **Radio**  **Radiology dept.**  **TV**  **Other (specify):     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

**Please FAX form to BCCHP Prime Contractor at:**