**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:**