Every Woman Counts
RECIPIENT ELIGIBILITY FORM

Medical Record Number **Recipient ID** 9A

This section to be completed by recipient

1. Last Name
2. First Name
3. Middle Initial
4. Date of birth (MM) (DD) (YYYY)
5. Mother's Maiden Name
6. Address
7. City
8. State
9. ZIP Code
10. Telephone

11. Are you Hispanic or Latino?
☐ Yes ☐ No ☐ Unknown

12. Select all that apply to you
- ☐ American Indian or Alaska Native
- ☐ Asian → ☐ 13.(Select one if Asian)
  - ☐ Asian Indian
  - ☐ Cambodian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American
- ☐ Pacific Islander → ☐ 14.(Select one if Pacific Islander)
  - ☐ Guamanian
  - ☐ Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ Unknown

15. Total household income (before taxes):
16. Total number of persons living together on this income:

17. Health insurance:
17a. Do you have health insurance? ☐ Yes ☐ No
17b. If Yes, which type?
☐ Medi-Cal ☐ Medicare Part B ☐ Military
☐ Family PACT ☐ Private insurance ☐ Other _____

18. Tobacco Use:
**18a. Do you smoke tobacco now? ☐ Yes ☐ No
**18b. Do you use other tobacco products now? ☐ Yes ☐ No

I certify that the above information is correct and complete:

Recipient Signature **Date Signed**

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

19. ☐ Meets *EWC* program age, income, and insurance criteria.
[≥ 40 years of age for Breast Services or ≥ 21 years of age for Cervical Services]
[≤ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]
20. ☐ Signed *EWC* consent form
21. ☐ Breast and Cervical Cancer Treatment Program—See page 2 for additional referral requirements

I have determined that this woman is eligible for *EWC* services*.

For recipients who answered Yes to ***Item 18a or 18b above, I have notified clinician to assess smoking status and refer to tobacco cessation resources.

Primary Care Provider Staff Certifying Signature **Date Certified**

**Eligibility determination policies and information are located in the Can Detect Portion of the Medi-Cal Manual.*

Every Woman Counts
RECIPIENT ELIGIBILITY FORM (continued)

BCCTP Enrollment Date:

The purpose of this enrollment is to only refer the recipient to BCCTP Breast Cancer Treatment:

☐ Breast Final Diagnosis Date:

Breast Final Diagnosis (check one):

- ☐ Atypical Ductal Hyperplasia (ADH)
- ☐ Lobular Neoplasia
- ☐ Lobular Carcinoma in Situ (LCIS)
- ☐ Atypical Lobular Hyperplasia (ALH) Ductal
- ☐ Carcinoma In Situ, Comedo Type Ductal
- ☐ Carcinoma In Situ, Non-Comedo Type
- ☐ Infiltrating Ductal Carcinoma
- ☐ Infiltrating Lobular Carcinoma
- ☐ Medullary Carcinoma
- ☐ Mucinous or Colloid Carcinoma
- ☐ Papillary Carcinoma
- ☐ Tubular Carcinoma
- ☐ Paget's Carcinoma of the Breast
- ☐ Malignant Phyllodes Tumor
- ☐ Metastatic Cancer with Breast Primary
- ☐ Carcinosarcoma
- ☐ Primary Non-Hodgkins Lymphoma
- ☐ Inflammatory Breast Carcinoma
- ☐ Adenoid Cystic Carcinoma
- ☐ Breast Malignancy NOS

The purpose of this enrollment is to only refer the recipient to BCCTP Cervical Cancer Treatment:

☐ Cervical Final Diagnosis Date:

Cervical Final Diagnosis (check one):

- ☐ High Grade Squamous Cell Intraepithelial Lesion (HSIL)
- ☐ Adenoid Cystic Carcinoma
- ☐ Cervical Intraepithelial Neoplasia II (CIN II)
- ☐ Cervical Intraepithelial Neoplasia III (CIN III)
- ☐ Atypical Glandular Cells of Undetermined Significance (AGUS)
- ☐ Adenocarcinoma In Situ (ACIS)
- ☐ Adenocarcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Adenoma Malignum
- ☐ Adenosquamous Carcinoma
- ☐ Glassy Cell Carcinoma
- ☐ Carcinoid Carcinoma
- ☐ Small Cell Carcinoma or Neuroendocrine Carcinoma
- ☐ Metastatic Cancer with Cervical or Endocervical Primary
- ☐ Cervical Sarcoma
- ☐ Cervical Melanoma
- ☐ Mesonephric Carcinoma
- ☐ Moderate Dysplasia
- ☐ Severe Dysplasia
- ☐ Carcinoma In Situ
- ☐ Malignant Mixed Mullerian Tumor
- ☐ Cervical Malignancy NOS

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

22. ☐ Meets *EWC* program age, income and insurance criteria.
    [≥ 40 years of age for Breast Services or ≥ 21 years of age for Cervical Services]
    [≤ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]
23. ☐ Signed *EWC* consent form

***I have determined that this woman is eligible for BCCTP enrollment.**

Primary Care Provider Staff Certifying Signature **Date Certified**

**Eligibility determination policies and information are located in the Cancer Detection Programs' Section of the Medi-Cal Manual.*

Every Woman Counts
RECIPIENT ELIGIBILITY FORM (continued)

PRIVACY STATEMENT

The information requested on this form, is required by the Department of Health Care Services (DHCS), Every Woman Counts (EWC) for purposes of client identification and data collection. This information may be transferred to federal, state, and local agencies for purposes of verifying eligibility and other purposes related to administering EWC. Furnishing the information requested on this form is mandatory. Failure to provide the required information may result in the denial of eligibility.

The Information Practices Act of 1977 and the Federal Privacy Act require DHCS to provide the following information: that privacy and confidentiality of all personal, confidential, and sensitive information, in whatever medium (oral, paper or electronic) must be protected. DHCS considers all information about individuals private, unless such information is determined to be a public record. DHCS and EWC policy is to protect privacy and prevent the loss of information through accidental misuse, sabotage, criminal activity, or natural disaster.

Legal references authorizing maintenance of this information: Government Code Section 6250-6265, Government Code Section 11019.9, Health and Safety Code Section 131085. All information will be protected as described in the Department's Cancer Detection & Treatment Branch CDTB Notice of Privacy Practices. You have the right to inspect or obtain a copy of records kept by the CDS regarding your health care, as described in the CDTB Notice of Privacy Practices. Contact the California Department of Health Care Services, Every Woman Counts 1616 Capitol Avenue, Suite 74-421 P.O. Box 997377, Sacramento, CA 95899-7377, or call (916) 449-5300.