

Medicaid Breast and Cervical Cancer Program Application



Louisiana’s Breast and Cervical Cancer Program is only for **women** who have been **screened** under the Center for Disease Control and Prevention’s (CDC) National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast and/or cervical cancer, including precancerous conditions. The program provides full Medicaid benefits, like prescriptions and hospital and doctor visits.

To apply:

1. **Get** a CDC screening by calling 1-888-599-1073.
2. **Fill out** this form and **sign** it.
3. **Mail** or **fax** the form and proof of screening and findings to your local Medicaid office as soon as possible.
4. **If you need help** with this form, call us toll free at 1-888-342-6207 (TTY: 1-800-220-5404).

What language do you speak best? English Spanish Vietnamese Other (specify) _____

What language do you write best? English Spanish Vietnamese Other (specify) _____

1. Give us the following information about yourself (person who is applying).

Name (First, Middle Initial, Last) _____

Social Security Number _____ Date of Birth _____

Are you Hispanic or Latino (**you do not have to answer**)? Yes No Unknown

Race (**mark one or more; you do not have to answer**) White Black or African American

American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander

U.S. Citizen Yes No Louisiana Resident Yes No

Mailing Address _____ City _____ State _____ Zip Code _____

Home Address _____ City _____ State _____ Zip Code _____

Parish _____ Home Phone Number (____) _____

Cell Phone Number (____) _____ Other Phone Number (____) _____

Best Day or Time to Call _____ E-Mail Address _____

- 2. Do you have proof of the Early Detection Program screening and diagnosis?** Yes No
 If **Yes**, please give us proof of the screening and findings. If **No**, please contact Louisiana’s Early Detection Program at 1-888-599-1073 to get the proof. (**You do not have to wait for the proof, apply now.**)
A screening is required to be eligible for Medicaid coverage under this program.

- 3. Do you have private health insurance?** Yes No If **Yes**, give the following information.

Insurance Company Name, Address, and Phone Number	Group/Policy Number	Is treatment of breast/cervical cancer covered?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Do you have a husband **living at home**? Yes No
5. How many children or other dependents under age 18 **live in the home**? _____
6. Are you pregnant? Yes No Best Estimate of Due Date _____
7. Do you have a disability? Yes No
8. Do you and/or your husband get money from anywhere? Yes No If **Yes**, tell us from where or who and the amount before any deductions (not take-home pay) that is (are) received each month. _____

Rights and Responsibilities

- * I state that everyone who is applying is a U.S. citizen or is in this country legally.
- * The information I gave on this form is true and correct. I understand if I on purpose give information that is not true OR if I on purpose do not tell information that I am supposed to, we may get health benefits that we should not get. If that happens, we can by law be punished for fraud. Also, we may have to pay money back to Medicaid for the bills it paid by mistake.
- * I understand that the information I give about us will be checked. I agree to help do that and to let Medicaid get information it needs from government agencies, employers, medical providers, and others.
- * I know that our Social Security numbers will only be used to get information from other government agencies to decide eligibility.
- * By accepting Medicaid, the Department has the right to get money received by us from other sources like insurance payments or lawsuit settlements for services that Medicaid has already paid for us.
- * We agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) changes in where we live or get our mail; 3) changes in health insurance and premiums; 4) changes in income; 5) changes in the things we own if anyone who gets Medicaid is disabled or over age 64; and 6) if a pregnancy ends.
- * We can ask for a Fair Hearing if we think any decision made on our case is unfair, incorrect or made too late.
- * Medicaid cannot treat us differently because of our race, color, sex, age, disability, religion, nationality or political belief. If I think they have, I can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 1349 Baton Rouge, LA 70821-1349.
- * Information about WIC, KIDMED, and other Medicaid services will be sent to me if we are eligible for Medicaid.

Signature of Applicant or Authorized Representative

Date

Signature of Agency Representative, if applicable

Date

Please mail this form as soon as possible to your local Medicaid Office. You can find your local Medicaid office by visiting our website at www.Medicaid.DHH.Louisiana.gov or by calling us at 1-888-342-6207 (TTY: 1-800-220-5404).