



## Breast and Cervical Cancer Medical (BCCM) Program Application and Referral Form

Agency  
Use Only

If the applicant does not speak or read English, complete the following:

What language does she speak? \_\_\_\_\_ What language does she read? \_\_\_\_\_

Does she need an interpreter?  Yes  No

If the applicant has a disability and needs to receive forms in a different format, what format does she need?

Braille      Audio Tape      Large Print      Computer Disk      Oral Presentation

To qualify for medical benefits from the Breast and Cervical Cancer Medical (BCCM) Program, a woman must:

- Have been screened for breast or cervical cancer under the Breast and Cervical Cancer Screening Program.
- Need treatment.
- Be less than 65 years old.
- Have no health insurance to pay for treatment.

Health insurance is:

- Individual or group health insurance
- Medicare
- Oregon Health Plan (Medicaid)
- Armed forces insurance
- Family Health Insurance Assistance Program (FHIAP)
- Oregon Medical Insurance Pool (OMIP)

If a woman qualifies, she will need to fill out more forms.

- The woman may be asked to fill out forms for other medical programs. This is to see if she can get benefits from a different program.
- The woman may be asked to fill out a form about her citizenship. She will get this form in the mail. She will not have to tell us about her citizenship if she only wants to get emergency medical benefits. She will still need to return the form to get any benefits.

The woman will be asked to give her Social Security Number (SSN). A woman who only wants to get emergency medical benefits is not required to give us her SSN. She can volunteer to give us her SSN. We will not share this information with INS.

**Questions about the application can be answered by calling the Oregon Health Plan Central Branch Office at 1-800-699-9075 or TTY 1-800-735-2900.**

**Please complete the following to apply for medical benefits from the BCCM program.**

Date \_\_\_\_\_

Applicant \_\_\_\_\_

Home Address \_\_\_\_\_  
City State Zip

Mailing Address \_\_\_\_\_  
City State Zip

Phone Number \_\_\_\_\_ Message Phone \_\_\_\_\_

A woman does not have to tell us her SSN when she only wants to get emergency medical benefits. She can tell us her SSN voluntarily.

Does the applicant only want emergency medical benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Social Security Number\* \_\_\_\_\_  
(\*Voluntary, if only applying for emergency medical benefits)

Date of Birth \_\_\_\_\_

What date was the applicant found to need treatment? \_\_\_\_\_

Does the applicant have any type of health insurance coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type of coverage is it (provide copy of insurance card, if available)? \_\_\_\_\_

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**The following questions are to help us determine if the woman may qualify for another medical program.**

Is the applicant a parent of a child in her home who is less than 19 years of age? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the applicant pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Has the applicant applied for disability benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Has the applicant been denied disability benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the applicant receiving disability benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

## Assignment of Rights to Medical Benefits

By asking for and receiving medical benefits, a person is giving to Department of Human Services (DHS) all rights to any medical support and to any third party payments for medical care. This allows DHS to seek payment from any third party liable to pay for the person's medical care.

## Estate Claim Statement

Upon a person's death, DHS may take money from the person's estate (as defined in ORS 414.104). The amount that can be taken is generally equal to the amount of medical benefits that a person received after age 55. If the person is permanently institutionalized (as defined in OAR 461-135-0832) at the time of death, medical benefits paid prior to age 55 may be recovered. The money to repay the medical benefits can be taken from the person's estate at the time of death. If the person has a surviving spouse, no claim will be made until his or her death. If there are surviving children under the age of 21, no claim will be made. If there are surviving children who are disabled, no claim will be made (ORS 115.125).

## Social Security Number

Social Security Numbers (SSN) are required for most people applying for medical benefits (42 USC Sec. 1320b-7) An applicant does not have to give us her SSN if she is only applying for emergency medical benefits.

The SSN will be used to:

- make sure nobody gets benefits in more than one household;
- see which benefits a person can get;
- make changes to large numbers of cases at one time;
- recover overpaid benefits;
- match our records against federal and state records. For example, Unemployment Compensation, Internal Revenue Service, Medicaid and Social Security records;
- gather workforce information and research. This helps lawmakers and agencies improve services to Oregonians.

## Non Discrimination Statement

Discrimination shall not occur against anyone in any Department of Human Services' (DHS) programs. Benefit decisions, hearings, or any program service shall occur without discrimination. This means without regard to age, race, color, sex, religion, national origin, political belief or disability. You can file a complaint if you think discrimination occurred against you in any DHS program. If you want to file a complaint or need more information, call your local DHS office.

Rights of Applicant

- To give true, correct and complete information.
- To ask about DHS programs, payments and services.
- To apply for DHS programs.
- To get courteous and fair treatment without discrimination.
- To get reasonable accommodation for any disabilities per the Americans with Disabilities Act.
- To refuse to allow the release of information given to DHS unless it is required by law.
- To ask for and get a receipt for any forms given to DHS.
- To talk with a person in charge.
- To ask for a hearing on any action you disagree with. You have 45 days from the date of the notice to do this. The request must be on an Administrative Hearing Request form (AFS 443). This form is available from any DHS office. Someone at the office can help you fill it out.
- To know if you qualify for benefits within 45 days.

Responsibilities of Applicant

- Give true, correct and complete information.
- Report the following changes within 10 days:
  - Changes of address
  - Changes of other health care coverage
 Report changes by calling the Oregon Health Plan Central Branch Office at 1-800-699-9075 or TTY 1-800-735-2900.
- Tell health care providers of other health care coverage before using your medical ID card.

By signing this application:

- I allow DHS to review my health care records. I allow DHS to share my health care records with DHS contractors and their providers.
- I understand the estate claim statement.
- I understand my rights and responsibilities as stated above.
- I affirm the information I have given in this application is true, correct and complete to the best of my knowledge.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**Agency Use Only - BCC Coordinator Information**

I affirm the above named applicant has been screened by the Breast and Cervical Cancer Program and is in need of treatment for breast or cervical cancer, including a precancerous condition.

Expected length of treatment: 6 months or less \_\_\_\_\_ Longer than 6 months \_\_\_\_\_

Signed Name of BCC Coordinator \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of BCC Coordinator \_\_\_\_\_ Phone Number \_\_\_\_\_