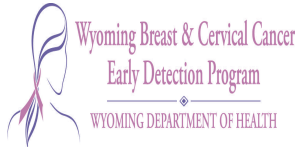


Mail to:

Wyoming Breast and Cervical Cancer Early Detection Program
Wyoming Department of Health
6101 Yellowstone Road, Suite 259 A
Cheyenne, WY 82002
1-800-264-1296
Fax 1-307-777-3765



Due no later than 30 days of signature.

Insurance: Do you have health insurance? Yes No
Do you have Medicaid (Title 19)? Yes No
Do you have Medicare Part B? Yes No

Personal Information

First Name: _____
Middle Initial: _____
Last Name: _____
Maiden Name: _____
Date of Birth: _____
Age: _____
Address: _____
City: _____ Zip: _____
Mailing Address: (if different than above) _____
City: _____ Zip: _____
County: _____
Home Phone: _____
Work Phone: _____
*Social Security Number: _____
Where were you born? _____
Are you a U. S. citizen? _____
If no, do you have legal documentation? _____

* Social Security Number is optional

Risk Factors

1. Have you had a hysterectomy? **Yes No**
If yes, was your cervix removed? **Yes No**
2. When was your last Pap test? _____
3. Was it abnormal? **Yes No**
**If yes, see instructions below for required report.
4. When was your last mammogram? _____
5. Was it abnormal? **Yes No**
**If yes, see instructions below for required report.
6. When was your last clinical breast exam? _____
7. Was it abnormal? **Yes No**
**If yes, see instructions below for required report.
8. Have you had breast cancer? **Yes No**
If yes, when? _____
9. Are you a current smoker? **Yes No**
10. Have you smoked (even one puff) in the last 30 days? **Yes No**
11. Have you smoked at least 100 cigarettes in your life-time? **Yes No**

Office Use Only
Approved Initials: _____
Denied Initials: _____
Date: _____
State ID #: _____

Income ~ (maximum gross before taxes)
Zero income will not be approved for enrollment.

Monthly household income: _____
Number of people in household: _____

****If you have had an abnormal clinical breast exam, Pap test and/or mammogram within the last three months, please request the report from your physician and mail the report with your application. If your report is not included, processing of your application will be delayed.**

How did you first learn about us? Please circle.

Health care provider: Name of provider: _____
Hospital • Radio • TV • Newspaper • Internet • Friend • Family Member • Health Fair •
Women Wellness Program • County Cancer Resource Coordinator (CCRC) • Native American Program
Other (specify): _____

Race/Ethnicity

Do you describe yourself as Spanish, Hispanic or Latino?

Yes No

Check all that apply:

- White
- Black or African American
- American Indian, Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander

Your Health Care Provider

Clinic Name: _____
Address: _____
City: _____ Zip: _____
Phone Number: _____

Other Contact ~ List someone who does not live with you.

Name: _____
Street Address: _____
City: _____ Zip: _____
Day Phone: _____
Relationship: _____

Sign Name: _____
Print Name: _____
Today's Date: _____ (mm/dd/yyyy)

Consent, Release, & Confidentially Statement

I understand that if I am accepted into this program, I may be required to repay any benefits I have received. Additionally, I could be prosecuted for fraud if (a) incorrect information was given and/or (b) changes in income and/or insurance status were not reported.

By agreeing to take part in this program, I give my permission to health care providers, billing agencies, Wyoming Department of Health, Wyoming Breast and Cervical Cancer Early Detection Program, the Centers for Disease Control and Prevention, and others involved in my care to share medical information obtained for the purpose of screening, diagnosis, treatment, and program evaluation.

I understand that information received by the Wyoming Breast and Cervical Cancer Early Detection Program will be treated as confidential and will only be available to others with a need to know. Reports will not identify individuals by name.

For additional information regarding the Wyoming Department of Health's privacy policy, visit the Department's HIPAA website <<http://www.health.wyo.gov/main/hipaa.html>> or call (307) 777-8664.

Please take the time to review your enrollment application. Be sure you have answered all the questions and have enclosed all required reports. Incomplete applications will be returned for completion. If you need help completing your application, call 1-800-264-1296 and press Option # 1 for assistance.

Visit our website at <http://www.health.wyo.gov/PHSD/bccedp/index.html>