

**Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)
Medicaid Application**

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY:

WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME:	FIRST NAME:	MI:	SOCIAL SECURITY NUMBER:		
ADDRESS:	CITY:	STATE:	ZIP:	STATE OF RESIDENCE:	
MAILING ADDRESS (if different):	CITY:	STATE:	ZIP:	HOME PHONE #:	DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: WHITE AMERICAN INDIAN/ALASKA NATIVE
 BLACK ASIAN/PACIFIC ISLANDER
 HISPANIC OTHER

MARITAL STATUS: NEVER MARRIED DIVORCED
 MARRIED WIDOWED
 SEPARATED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES NO IF NO, ALIEN NUMBER: _____

DO YOU RECEIVE SSI? YES NO ARE YOU PREGNANT? YES NO DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES NO

DO YOU HAVE HEALTH INSURANCE? YES NO IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES NO IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER: _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:

I have the right to:

- ♦ Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- ♦ Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services.
- ♦ Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- ♦ Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- ♦ Report any changes in information provided on this form within 10 days to my local department of social services.
- ♦ Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- ♦ This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- ♦ The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- ♦ The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- ♦ Each provider of medical services may release any medical records pertaining to any services received by me.
- ♦ I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

Signature or Mark

Date

Witness/Authorized Representative

Date

Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

- I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- Yes, I would like to apply to register to vote. (please fill out the voter registration application form)
- No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, phone (804) 864-8901.

Applicant Name

Signature

Date

(For agency use only)

Voter Registration form completed: Yes No

Voter Registration form given to applicant for later mailing (at applicant's request):

Agency Staff Signature

Date