N.C. Department of Health and Human Services Division of Health Benefits
Breast and Cervical Cancer Medicaid Application

*Do not send application to the patient or to Department of Social Services. Contact the BCCCP provider/navigator in the county of the patient's residence to complete this application. https://bcccp.ncdhhs.gov/BCCM.htm

SECTION I. Answer the questions in Section I to determine if application needs to be completed for person needing help with medical bills.

1 Person has been enrolled in the North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) OR has been newly diagnosed outside of NC BCCCP and has received screening and/or diagnostic testing per the guidelines, and needs treatment for breast or cervical cancer including pre-cancerous conditions and early stage cancer.
(Definition of pre-cancerous condition for cervical cancer: High Grade Squamous Intraepithelial Lesion [HSIL]).

☐ Yes **-** Diagnosed in NC BCCCP OR ☐ Yes- Diagnosed outside NC BCCCP and meets all other NC BCCCP eligibility criteria

☐ NO - The woman is ineligible for Breast and Cervical Cancer Medicaid. ***STOP!*** **Go no further.**

2. Person has not attained age 65.
☐ ***Yes -*** Continue to question 3.
☐ ***No -*** The woman is ineligible for Breast and Cervical Cancer Medicaid. ***STOP!*** **Go no further.**

3. Is this person a U.S. citizen, lawful permanent resident (admitted to the U.S. more than 5 years ago) or a refugee from another country?
☐ ***Yes*** - Make copies of INS documentation and attach with application if person is LPR or refugee. Continue to question 4.
☐ ***No -*** The woman is ineligible for Breast and Cervical Cancer Medicaid. ***STOP!*** **Go no further.**

4. Person has major medical insurance, which is defined as current coverage under a group health plan, including authorized for Medicaid and/or Medicare Part A or B, health insurance coverage (either individual or group), a military-sponsored health care program, a state health risk pool. Check Yes (she has insurance) or No (she does not have insurance.)

☐ ***Yes -*** The woman is ineligible for Breast and Cervical Cancer Medicaid, UNLESS coverage consists solely of limited benefits such as accidents or limited-scope dental, vision, or long-term care insurance. There may also be limited circumstances where a woman has major medical insurance, but she is not actually covered for treatment of breast or cervical cancer. If you have a question about an insurance policy, call the State Medicaid Eligibility Unit at (919) 855-4000.
- ❖ If the woman has limited medical insurance coverage, make a copy of the Insurance Card (front and back). Attach the copy to this application. Continue to question 5.
- ❖ If coverage is not limited, ***STOP!*** **Go no further. This person is ineligible.**

☐ ***No -*** Continue to question 5.

5. **Is this person any of the following: (Check Yes or No)**
A.) Pregnant ☐ ***Yes*** ☐ ***No***
B.) Blind ☐ ***Yes*** ☐ ***No***
C.) Disabled (determined by Social Security) ☐ ***Yes*** ☐ ***No***
D.) Under age 21 ☐ ***Yes*** ☐ ***No***
E.) Former NC Foster Care Child receiving Medicaid at age 18 ☐ ***Yes*** ☐ ***No***
F.) A caretaker relative of a child(ren) in the home under age 18? ☐ ***Yes*** ☐ ***No***

If the answer is **"No"** to all the questions in 5. A-F, **complete Section II only**, to gather applicant identifying information. Have the applicant and the person completing the form sign and date the application. This application is only for Breast and Cervical Cancer Medicaid Coverage.

If **"YES"** to any of the questions in 5. A-F, **continue with Section II and Section III** of this application. Person may be eligible for another Medicaid program.

SECTION II. Information on Applicant

Name of Applicant

_____

First Middle Initial Maiden Last

Home Address

_____ NC _____

Street Address or P.O. Box City State Zip County

Home Telephone # or # where applicant can be reached during the day _____

Social Security # _____ **Date of Birth** (_____/_____/_____)

Applicant status: (Check current status)

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: (Check all that apply)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity: (Check yes or no) Hispanic/Latino ☐ ***Yes*** ☐ ***No*** **If yes, specify:** ☐ Hispanic Puerto Rican

☐ Hispanic Cuban ☐ Hispanic Mexican ☐ Hispanic Other

Language Preference: (Check or List one) ☐ English ☐ Spanish ☐ Other _____

Retroactive Coverage-Does applicant need help paying medical bills for herself for the past three months prior to the date of this application?
☐ **Yes** ☐ **No**
If yes, please complete the information below. Medicaid may be able to help with those bills.

Name of doctor, clinic, or hospital where the person was seen	Date of medical treatment

Applicant's Acknowledgement
- I either read or had read to me all parts of this application and I understand my rights and responsibilities as an applicant/recipient. Rights and Responsibilities are on the last page of this application.
- I authorize the release of any information necessary to establish my eligibility. This release is good for one year from the date of this application.
- This authorization to release information may be reproduced.
- All information I give is confidential.
- I attest that all statements recorded on this document are true and correct to the best of my knowledge.

Applicant needs to read "Rights and Responsibilities" on the last page of the application before signing.
Applicant's Signature _____ **Date**_____

Signature of Screening Provider Completing Form_____**Title**_____

_____ _____
Medicaid Provider Number **Telephone**

Fax completed application and completed DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid to the applicant's county department of social services.

SECTION III. Complete this section if applicant answered YES to A, B, C, D, E, or F on question #5 in Section I.

INCOME- List income earned by applicant and/or her spouse. Income includes wages, tips, or salary received by applicant and/or her spouse who works. **Attach copies of last month's paystubs.** (Last month is the month prior to the date application completed.) Provide copies of current business records for the past 6 months if self-employed (or past 12 months if income is received annually).

List name of person working	Employer's name or type of business if self-employed	How often paid? Monthly, Weekly, etc.	Gross amount (before any taxes or deductions)

BENEFITS - Unearned income such as Social Security, SSI, Unemployment benefits, retirement benefits, child support, private or employer sponsored disability etc. Provide copies of check, award letters, or other proof of this income.

List name of person receiving.	List where income is from. (EX: Child Support, Social Security)	How Often Received? Monthly, Weekly, etc.	Gross Amount

Does applicant or spouse pay child support for a child who is not in the home? ☐ **Yes** ☐ **No**

Who pays the support? _____ Amount paid?_____ How Often? _____

Was this person ordered by the court to pay support? ☐ **Yes** ☐ **No**

Does applicant or spouse pay childcare or care for an incapacitated adult? ☐ **Yes** ☐ **No**

How much is paid? _____ How Often? _____

RESOURCES

Does applicant or her spouse have any of the following? (Check Yes or No) **The county DSS will complete verifications column.**

SOURCE	YES	NO	Owner? /Where Located?	Value	Verifications
CASH					
CHECKING					
SAVINGS					
CD'S					
STOCKS/BONDS					
TRUST FUNDS					
REAL PROPERTY/HOME					
HEIR or OTHER PROPERTY					
FARM/BUSINESS PROPERTY OR EQUIPMENT					
BURIAL CONTRACTS					
OTHER					

Does applicant or spouse have any cars? - ☐ YES ☐NO **(The county DSS will complete last 2 columns)**

MAKE	MODEL	YEAR	OWNER	VALUE	VERIFICATION

Does applicant or spouse have life insurance policies? ☐ Yes ☐ No If yes, list below.

Owner of policy	Policy Number	Name of Insurance Company	Face Value	Cash Value	Name of Insured

Double Check:

1. *Page 2 of application is signed and dated by applicant.*
2. *All questions are answered, and copy of "Rights and Responsibilities" given to applicant*
3. *All verifications that are available are faxed and mailed with this form and DMA-5081 to the applicant's county department of social services.*

Breast and Cervical Cancer Medicaid
"Rights and Responsibilities"

Notification of Decision

Your county department of social services will process your application for Breast and Cervical Cancer Medicaid coverage quickly. The sooner you get information we may need to us, the sooner we can process your application for medical coverage. If additional information is needed you will be contacted by mail or telephone. Be sure to list correct address and phone numbers so you may be contacted.

Your Rights and Responsibilities

Rights:

- Apply for assistance and, if found ineligible may reapply at any time.
- Not be discriminated against because of race, color, national origin, sex, religion, age or disability.
- Have the information you provide kept in confidence.
- Ask for help with medical transportation, if found eligible for Breast or Cervical Cancer Medicaid. If transportation is provided, it will be to the nearest appropriate medical provider of your choice, by the least expensive method. To request transportation assistance, contact your county department of social services.
- Withdraw from the program at any time.
- Receive assistance if found eligible.
- Receive a copy of the "Medicaid Notice of Privacy Practices."
- Appeal to the county department of social services for a hearing if:
  - You were denied the right to apply for assistance.
  - You were encouraged to withdraw your application.
  - Your application was denied, and you believe the decision is incorrect.
  - You believe your assistance is incorrect.

***Responsibilities**:*

- I agree to provide all necessary information to help county, state or federal Medicaid agencies determine my eligibility.
- I agree to notify the county department of social services within 10 calendar days of any changes in my address, plans to move, availability of other health insurance, or if I am no longer receiving treatment for cancer.
- I agree to provide a social security number or apply for a social security number for myself, or anyone for whom I am applying for Medicaid, if one has not been issued. I understand these social security numbers will be used in matching information with the Social Security Administration (SSA), Internal Revenue Service (IRS), Employment Security Commission (ESC), out-of-state Social Services and ESC agencies, and any other agencies, when applicable. If I do not want these social security numbers to be used in the matches, I understand I have the right to withdraw my application or have my assistance terminated.
- I certify that the information I have provided is a true and complete statement of facts. I understand that State and Federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance.
- I certify I currently live in North Carolina and intend to remain.