Washington State Department of Health
DOH 342-054 July2020

SPOKANE REGIONAL HEALTH DISTRICT
PHONE 509-323-2851 FAX 509-324-1599
WWW.SRHD.ORG

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

BCCHP ENROLLMENT FORM

Please Print **New to BCCHP?** ☐ **Yes** ☐ **No** **Authorization #**

Last Name	**First Name**	**MI**	**Authorized for:** ☐ **CBE** ☐ **Pelvic** ☐ **Pap** ☐ **Mammogram**
Gender: ☐ **Female** ☐ **Male** ☐ **Transman** ☐ **Transwoman** ☐ **Genderqueer** ☐ **Gender Non-Binary** ☐ **Agender** ☐ _____ **Services of interest:** ☐ **Breast** ☐ **Cervical**			**Prime Contractor** **SPOK** / **Date**
Date of Birth	**Last 4 Digits SSN (Optional)**		**Clinic / Screening Site**
Address			**Appointment** **Date:** **Time:**
City	**State**	**Zip Code** / **County**	**Clinic Chart #**

Telephone Numbers: OK to leave a message? ☐ **Yes** ☐ **No** **Best time to call:** ☐ **a.m.** ☐ **p.m.**
Home: **Cell:** **Work:** **Alternate:**

Program Eligibility: must be completed annually

Household income before taxes? $ _____ **Per** ☐ **Month** ☐ **Year** How **many people live on this income? _____**

Checked eligibility for Apple Health ☐ **Yes** ☐ **No (reason _____) Date:**
Eligible for Apple Health ☐ **Yes** ☐ **No** **Enrolled on Apple Health** ☐ **Yes** ☐ **No Date:**

Do you have? (select all that apply) ☐ **No Health Insurance & Not Eligible for Apple Health (attach denial if available)**
☐ **Medicare Part B** ☐ **Apple Health, Medicaid, Provider One # _____**
☐ **Insurance** **Name of company: _____** **Deductible: $_____** **Policy/ID #: _____**

Do you have any problems with your breasts? ☐ **Yes** ☐ **No** **If yes, what problem?** _____
_____

Primary Language? (check all that apply, circle prefer) ☐ **English** ☐ **Spanish** ☐ **Vietnamese** ☐ **Chinese** ☐ **Korean**
☐ **Cambodian** ☐ **Russian** ☐ **Other (specify:)** **Do you need an interpreter?** ☐ **Yes** ☐ **No**

What race do you think of yourself? (Mark one or more)
☐ **Asian** ☐ **Black or African American** ☐ **American Indian or Alaska Native (specify tribe:)**
☐ **White or Caucasian** ☐ **Native Hawaiian or other Pacific Islander (specify:)** ☐ **Unknown**

Do you consider yourself Latina/Latino or Hispanic? ☐ **Yes** ☐ **No**

What is the highest grade of school you have completed? (number of school years) _____

If you are NEW to BCCHP, how did you learn about this program? (select only one)

☐ **Clinic**	☐ **Friend or relative**	☐ **Radio**
☐ **Community organization**	☐ **Internet search – BCCHP website**	☐ **Radiology dept.**
☐ **Employer**	☐ **Mailing**	☐ **TV**
☐ **Outreach worker**	☐ **Poster, Flyer or Brochure**	☐ **Other (specify):** _____

Please FAX form to BCCHP Prime Contractor at: 509-324-1599

To request this document in another format, call 1-800-525-0127.
Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.