



Breast and Cervical Cancer Treatment Program (BCCTP) User Guide

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Overview

The Breast and Cervical Treatment Program (BCCTP) provides urgently needed cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer who have met the Centers for Disease Control and Prevention (CDC) screening criteria. Every Woman Counts (EWC) and Family Planning, Access, Care, and Treatment (Family PACT) screening providers are authorized to screen and enroll applicants into BCCTP. These providers enroll eligible applicants into BCCTP by using the Breast and Cervical Treatment Program (BCCTP) application in the Medi-Cal Provider Portal.

Objectives

The objective of this user guide is to provide step-by-step instructions for submitting presumptive eligibility requests in the Medi-Cal Provider Portal BCCTP application.

Tips and Troubleshooting

- Required fields are indicated by an asterisk (*). Fields without an asterisk are optional.
- Each session will have a 30-minute time-out if no action is taken. To ensure that progress isn't lost, it is recommended that you review and complete the online application in a timely fashion.

Prepare to Submit a BCCTP Application

There are two documents that will help prepare a provider to submit a BCCTP presumptive eligibility request in the Medi-Cal Provider Portal Breast and Cervical Cancer Treatment Program (BCCTP) application:

- *Breast & Cervical Cancer Treatment Program (BCCTP) Application Information & Instructions for Providers*
- *Breast and Cervical Cancer Treatment Program Medi-Cal Application*

Both of these documents may be accessed from the **Resources** drawer in the BCCTP application. Refer to the “Access Provider Portal BCCTP Application” section of this user guide.

Breast & Cervical Cancer Treatment Program (BCCTP) Application Information & Instructions for Providers

The purpose of the *Breast & Cervical Cancer Treatment Program (BCCTP) Application Information & Instructions for Providers* document is to assist providers in determining if an individual is eligible to submit a BCCTP application.

Breast and Cervical Cancer Treatment Program Medi-Cal Application

The *Breast and Cervical Cancer Treatment Program Medi-Cal Application* document must be printed and completed with an applicant to determine if the individual is eligible for Medi-Cal under BCCTP rules. The document must be signed by the applicant and submitted to DHCS one of the following ways:

- Email to BCCTP@dhcs.ca.gov
- Fax to 916-440-5693
- Mail to:

Department of Health Care Services
Breast and Cervical Cancer Treatment Program
MS 4611
P.O. Box 997417
Sacramento, CA 95899-7417

Access Provider Portal BCCTP Application

1. Navigate to the [Medi-Cal Providers website](#) and click **Login to Provider Portal**.

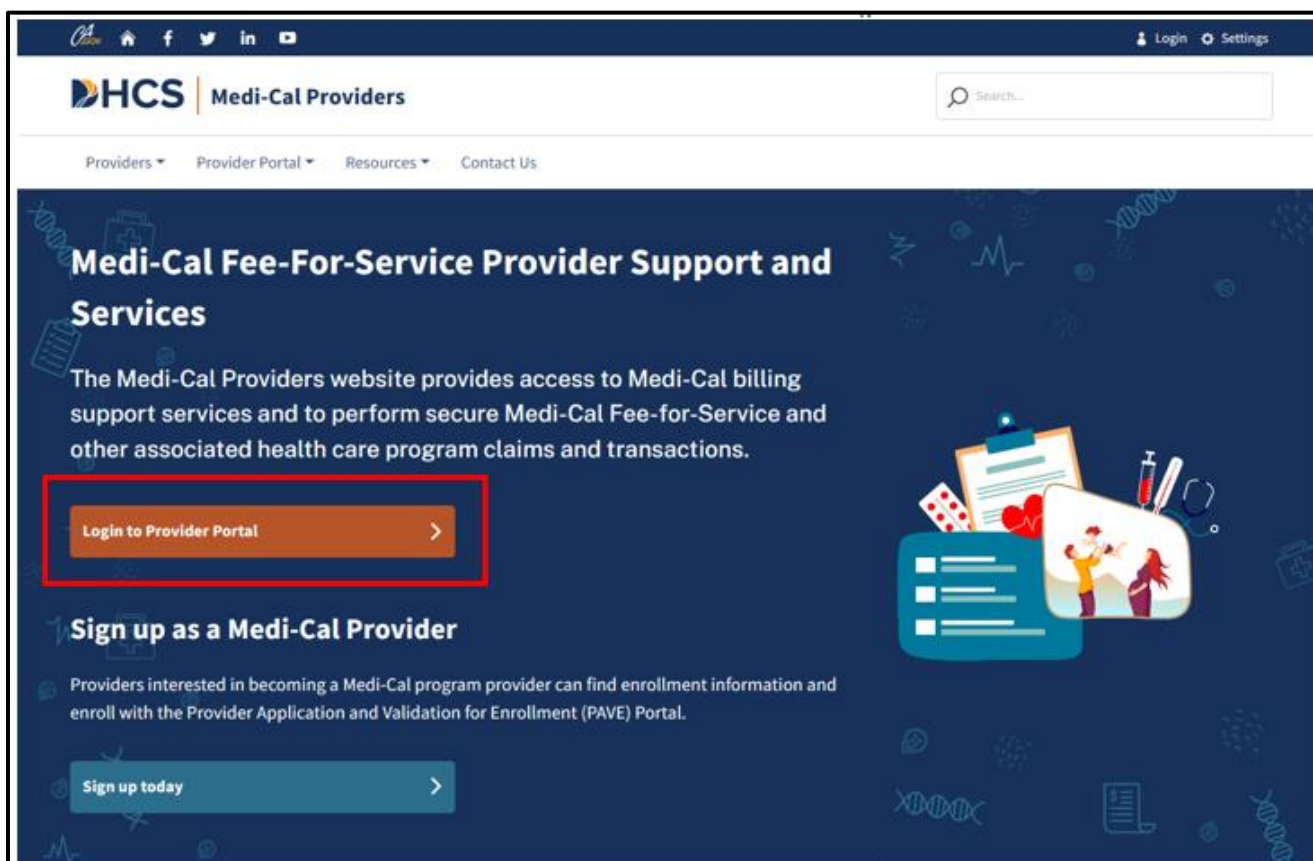


Figure 1.1: Provider Portal Link.

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2. On the Dashboard Transaction Center tile, click **Get Started**.

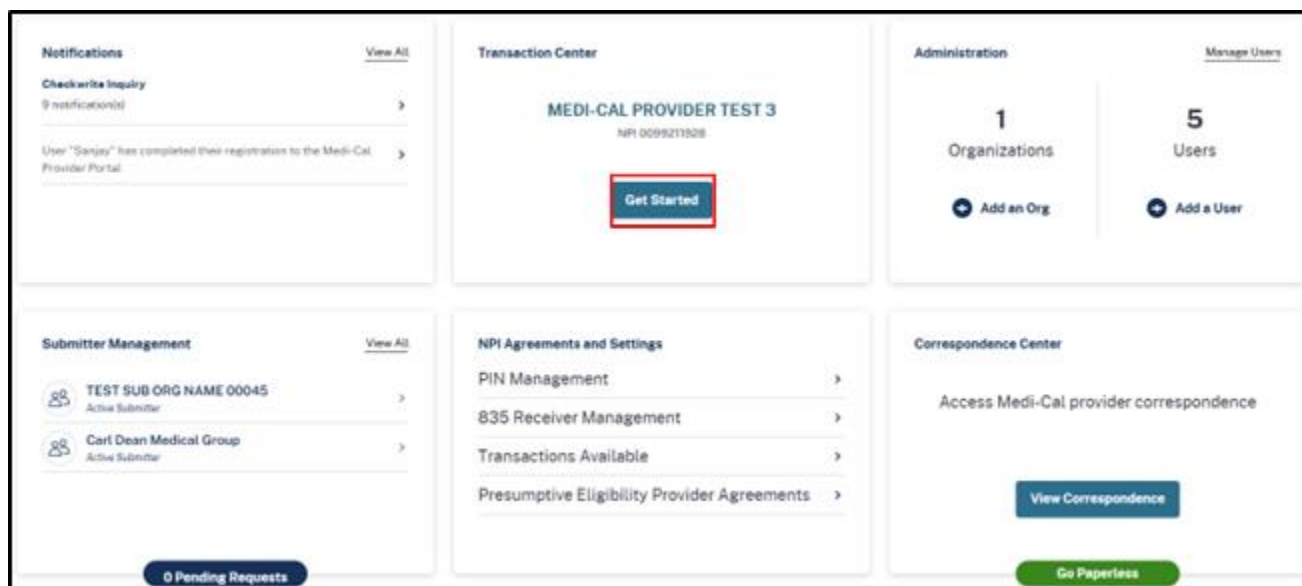


Figure 1.2: Get Started.

3. In the Enrollment section, click **Breast and Cervical Cancer Treatment Program**.

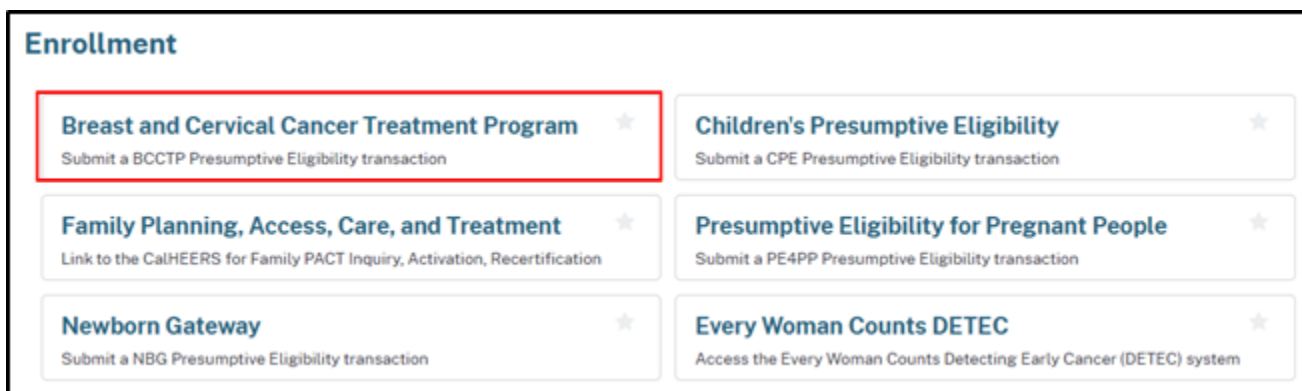


Figure 1.3: Breast and Cervical Cancer Treatment Program Link.

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- Click the **Resources** drawer.

The screenshot shows the 'Breast and Cervical Cancer Treatment Program (BCCTP)' interface. The top navigation bar includes 'HCS Medi-Cal Providers', a search bar, and links for 'Providers', 'Provider Portal', 'Resources', and 'Contact Us'. A 'Notifications' bell icon is also present. The main header displays the program name and an 'Organization Name' dropdown. On the left, a vertical sidebar lists steps: 'Provider Information' (selected), 'Provider Contact Information', 'Applicant Information', 'Verification', and 'Signature and Certification'. The main content area is titled 'Provider Information' and contains a text box for 'Provider Number' (1234567890), a 'Screened by' dropdown, a 'Screen Date' date picker, a 'Diagnosed by' dropdown, a 'Diagnosis Date' date picker, and two more dropdowns for 'Breast Cancer Diagnosis' and 'Cervical/Endocervical Diagnosis'. A 'Resources' drawer is open on the right side, highlighted with a red box.

Figure 1.4: Resources Drawer.

- Click Downloads.

The screenshot shows the 'Resources' drawer, which is a modal window with a close button (X) in the top right corner. It contains a 'BCCTP FAQ' section with the text 'Find answers to the most common questions about BCCTP'. Below this, the 'Downloads' link is highlighted with a red box, accompanied by the text 'Available downloads about BCCTP' and a right-pointing arrow.

Figure 1.5: Downloads Link.

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6. Click **BCCTP Application** in English or Spanish to download, print and complete the application with a patient. The application is available in other threshold languages on the Medi-Cal Providers website.



Figure 1.6: Download Application.

Submit BCCTP Application

After collecting the applicant's information and signature from the *Breast and Cervical Cancer Treatment Program Medi-Cal Application*, enter the information in the Provider Portal BCCTP application.

1. In the Provider Portal BCCTP application, complete the **Provider Information** page and click **Next**.

Provider Information * Indicates required field

By submitting this application, I attest that this BCCTP applicant meets all of the eligibility screening criteria, including the income requirements for Every Woman Counts (EWC) or the Family Planning, Access, Care and Treatment Program (Family PACT).

Provider Number: 1234567890

Screened by * **Screen Date ***

Select mm/dd/yyyy

Diagnosed by * **Diagnosis Date ***

Select mm/dd/yyyy

Breast Cancer Diagnosis **Cervical/Endocervical Diagnosis**

Select Select

[Cancel](#) [Next](#)

Figure 2.1: Provider Information.

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2. Complete the **Provider Contact Information** page and click **Next**.

The screenshot shows the 'Provider Contact Information' form in the BCCTP system. On the left is a vertical navigation menu with five items: 'Provider Information' (checked), 'Provider Contact Information' (highlighted), 'Applicant Information', 'Verification', and 'Signature and Certification'. On the right is a 'Resources' button. The main form area has a title 'Provider Contact Information' and a note: '* Indicates required field'. Below this is a paragraph: 'Please complete this section in its entirety as we will have to contact you if there are any questions about the application once submitted.' and a prompt: 'Enter name of staff person submitting this on-line application'. The form contains several input fields: 'Staff Last Name *', 'Staff First Name *', 'Staff Title *', 'Direct Telephone Number *' (with a placeholder '(AAA) BBB-XXXX'), 'Extension' (with a placeholder 'XXXX'), 'Facility/ Office Information' section with 'Facility/Office Name *', 'Street Address *' (with a placeholder 'Number and Street'), 'City *', 'State *' (a dropdown menu showing 'CA'), 'ZIP Code *', 'Best Time to Call' (a dropdown menu), 'Email Address', 'Alternate Staff Contact Person', and 'Facility/Office Telephone Number (if different)' (with a placeholder '(AAA) BBB-XXXX'). At the bottom are three buttons: 'Cancel', 'Previous', and 'Next' (which is highlighted with a red border).

Figure 2.2: Provider Contact Information.

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- Complete the **Applicant Information** page and click **Next**.

Provider Information

Provider Contact Information

Applicant Information

Verification

Signature and Certification

Applicant Information

* Indicates required field

Personal and Contact Information

If you only use one name, enter pound sign (#) in First Name field and enter your name in the Last Name field only.

Last Name *

First Name *

Mobile Initial

Suffix

Social Security Number

A Social Security Number is required for full benefits. If you do not have one now, you can apply now and give us the number within 60 days, or if you are an undocumented immigrant, you can obtain breast and cervical cancer treatment emergency service without a Social Security Number.

Gender *

Date of Birth *

Place of Birth

County of Birth (If California)

State of Birth (If Not California County)

Home Address

☐ If homeless, check the box and indicate (below) where to send any written correspondence.

In Care of (IC/O):

Street Address *

City *

State *

ZIP Code *

County you live in? *

Mailing Address (if different than above)

In Care of (IC/O):

Street Address

City

State

ZIP Code

Contact Information

What is the best way to contact you?

Email Address

What is the best time to call?

Home Phone

Message Phone

Mobile Phone

Spoken Language *

Written Language *

Medicare Coverage Information

	Yes	No
Do you have Medicare Part A (Inpatient)? *	<input type="radio"/>	<input type="radio"/>
Do you have Medicare Part B (Outpatient)? *	<input type="radio"/>	<input type="radio"/>
Do you have Medicare Part D (Prescription Drug Coverage)? *	<input type="radio"/>	<input type="radio"/>

Other Health Insurance Information

	Yes	No
Do you have other comprehensive medical coverage? *	<input type="radio"/>	<input type="radio"/>

If yes, identify Health Insurance Carrier(s). Select ALL that apply: *

☐ Military Benefits Comprehensive
 ☐ Medicare Part C (Advantage)
 ☐ Medical Parolee
 ☐ PPO/HMO/EPO

☐ Multiple Plans Comprehensive
 ☐ Kaiser
 ☐ Any carrier outside of those listed (includes multiple coverage)

Cancel

Previous

Next

Figure 2.2: Applicant Information.

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4. Complete the **Verification** page and click **Next**.

✓ Provider Information

✓ Provider Contact Information

✓ Applicant Information

Verification

○ Signature and Certification

Verification

* Indicates required field

Additional Questions

	Yes	No
This form is to apply for immediate Medi-Cal health care services for this month and next month. Do you also want to use this application to get ongoing Medi-Cal coverage through BCCTP? *	<input type="radio"/>	<input type="radio"/>
You must apply for Medi-Cal at your local county social services office to continue your BCCTP benefits. This is because you need to be evaluated for all benefits. You do not need to apply at the county if you have submitted a Medi-Cal application within the last 45 calendar days of this application date.		
Have you had medical expenses within the last three (3) months? *	<input type="radio"/>	<input type="radio"/>

Medi-Cal

Do you have a Benefits Identification Card (BIC)/Client Identification Number (CIN)? *

BIC/CIN

What is the identification number on your card? (if available)

Insert

Applicant Information

	Yes	No
Are you pregnant? *	<input type="radio"/>	<input type="radio"/>
How many children are you expecting? *	Children Expected: <div>Insert</div>	

Your answers to these questions provide information about your family size. Be sure to count your unborn child(ren).

Household and Income Details

How many family members live in your household? *

Insert

(Include parent, spouse, and any children under age 21 living in the household)

How much is your monthly household income before taxes? *

Insert

Alternate Forms

	Yes	No
Do you need information in an alternative format?	<input type="radio"/>	<input type="radio"/>
Select a format type: *	Format Type: <div>Braille</div>	

Cancel

Previous

Next

Figure 2.3: Verification.

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5. The **Signature and Certification** page contains a checkbox for providers to attest that the applicant has signed the paper *Breast and Cervical Cancer Treatment Program Medi-Cal Application*. Select the checkboxes and click **Next**.

Signature and Certification * Indicates required field

By submitting this application, I attest that this BCCTP applicant meets all of the eligibility screening criteria, including the income requirements for Every Woman Counts (EWC) or the Family Planning, Access, Care and Treatment Program (Family PACT).

☐ Check this box to certify that the applicant has signed the application. *

☐ Check this box to certify that the applicant has signed the Rights and Responsibilities form. *

[Cancel](#) [Previous](#) [Next](#)

Figure 2.4: Signature and Certification.

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- Read the Application Summary, ensuring that all of the information is correct. If a correction is required, click **Previous** to correct any errors on a previous page, Click **Print** at the top of the screen to print two (2) copies of the Application Summary. Provide one copy to the applicant and place a second copy in the individual's file. Click **Submit**.

✓ Provider Information

✓ Provider Contact Information

✓ Applicant Information

✓ Verification

✓ Signature and Certification

Application Summary

Print

BREAST AND CERVICAL CANCER TREATMENT PROGRAM APPLICATION

Application Date/Time: 01/23/2024 11:42:01 AM

PROVIDER CONTACT INFORMATION

Service Location

Kaiser

Service Location Address Number and Street

1234 Street Name

City

Cityexample

State

Stateexample

ZIP Code

90000

Staff Last Name

Staff First Name

Staff Title

Direct Telephone Number

Nameexample

Nameexample

Titleexample

(000) 000-0000

Facility/Office Email Address

email@example.com

Facility/Office Telephone Number (if different)

(000) 000-0000

APPLICANT INFORMATION

Last Name

First Name

Middle Initial

Suffix

Nameexample

Nameexample

☐ If homeless, check the box and indicate (below) where to send any written correspondence.

Home Address Number and Street

City

State

ZIP Code

1234 Street Name

Cityexample

Stateexample

90000

Mailing Address (if different) Number and Street

City

State

ZIP Code

Date of birth (month/day/year)

Gender

Applicant's Social Security Number

01/23/2023

Female

000-00-0000

County of residence

County of birth

State of birth

Countyexample

Countyexample

Stateexample

Spoken Language

Written Language

English

English

Do you have Medicare Part A (Inpatient)?

Do you have Medicare Part B (Outpatient)?

No

No

Do you have Medicare Part D (Prescription Drug Coverage)?

Do you have other comprehensive medical coverage?

No

No

VERIFICATION

Do you also want to use this application to get ongoing Medi-Cal coverage through BCCTP?

No

Have you had medical expenses within the last three (3) months?

No

Do you have a Benefits Identification Card (BIC)?

Applicant's BIC/ID

No

Are you pregnant?

Children Expected

No

How many family members live in your household?

Monthly Income Amount

3

\$3,000

Do you need information in an alternative format?

Format Type

No

WHO CAN SIGN THIS APPLICATION?

- The person who wants Medi-Cal, or the spouse of the person who wants Medi-Cal.
- The conservator, guardian, executor, or caretaker of a child who wants Medi-Cal.
- Someone acting for the person who needs Medi-Cal when the person is incompetent, in a comatose condition, or suffering from senility and there is no spouse, conservator, guardian or executor.

SIGNATURE AND CERTIFICATION

☒ Check this box to certify that the member has signed the application.

☒ Check this box to certify that the member has signed the Rights and Responsibilities form.

REQUIRED:

1. Enter Application tracking Number (located in the center of the Confirmation Document.)

- at the top of each page of the application (where indicated).
- at the bottom of each page of the Rights & Responsibilities form (in the application tracking Number box). Include the name of the beneficiary in the Name box as well.

SUBMIT APPLICATION:

1. Email to bcctp@dhcs.ca.gov OR;
 2. Fax to 916-440-5693 OR;
 3. Mail the following documents via USPS to the address below:

- Original signed Application
- Original signed Rights and Responsibilities forms

Department of Health Care Services

Breast and Cervical Cancer Treatment Program

MS 4010

P.O. Box 967417

Sacramento, CA 95899-7417

Cancel

Previous

Submit

Figure 2.5: Application Summary.

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7. A **Confirmation Document** appears with a response message. The individual and provider must read the response message carefully because it contains important information about the applicant's presumptive eligibility. Click **Print** to print two (2) copies of the **Confirmation Document**. Give one to the applicant for immediate use until a Benefits Identification Card (BIC) is received through the mail. Place the other copy in the individual's file. Provide a paper copy of the *Breast and Cervical Cancer Treatment Program Directions to Apply for Medi-Cal*, available on the Medi-Cal Providers website, whether the individual is eligible or not for BCCTP PE.

Note: If the applicant would prefer a large print version of the **Confirmation Document**, the user may select the checkbox to **View response message in a larger font**, which will print the document in a large print version.

To initiate another transaction, click **Next Application**.

The screenshot shows a web interface titled "Confirmation Document". At the top left, there is a checkbox labeled "View response message in larger font" which is currently unchecked. Below this is a large rectangular area containing the "Breast and Cervical Cancer Treatment Program Response". This section includes the "Application Date/Time: 10/23/2024 11:42:01 AM" and a list of fields: "Provider Number: 0123456789", "Member Name: TEST TESTING", "Date of Birth: 12/12/1999", "BIC: [redacted]", "BIC Issue Date: 01/23/2024", and "Application Tracking #: 38495". A large, faint watermark of the Seal of the State of California is visible in the background. Below the fields is a paragraph of text: "Response #0023: You have been granted temporary, full-scope Medi-Cal coverage effective today under the Breast and Cervical Cancer Treatment Program (BCCTP) while your ongoing eligibility is being decided. Use this Confirmation Document to get all of your medical services with a Medi-Cal doctor until you get your Benefits Identification Card in the mail. Your State Eligibility Specialist will tell you when your ongoing eligibility has been decided. If you have any questions about your application for this program, please call 1-800-824-0088 (toll-free)." At the bottom of this section is a line for "Client Signature:". At the bottom right of the interface, there are two buttons: "Print" and "Next Application", both of which are highlighted with a red rectangular border.

Figure 2.6: Confirmation Document – Eligible for PE.

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Confirmation Document
☐ View response message in larger font

Breast and Cervical Cancer Treatment Program Response
Application Date/Time: 10/14/2024 3:27:58 PM
Provider Number: #####
Member Name: Test Testing
Date of Birth: MM/DD/YYYY
BIC/CIN: #####A####
BIC Issue Date: MM/DD/YYYY
Application Tracking #: ####
Response ###: You are not eligible for Presumptive Eligibility (PE) because you have already received PE enrollment within the past 12 months. Individuals are limited to one PE enrollment within the past 12 months of applying.
Client Signature: _____

Print

Next Application

Figure 2.7: Confirmation Document – Not Eligible for PE.

Change Summary

Version Number	Date	Description	Notes/Comments
1.1	May 2025	New Provider Portal User Guide for the BCCTP Medi-Cal Application	Provider Portal project
1.2	September 2025	Title change	None
1.3	October 2025	User Guide Template update.	Removed “Page Updated: Month Year” on each page. Changed CA-MMIS to California Medicaid Management Information System.