Every Woman Counts Program – Recipient Enrollment Application

Thank you, for your interest in the California Department of Health Care Services (DHCS), Every Woman Counts (EWC) Program. EWC provides free breast and cervical cancer screening and diagnostic services to individuals living in California. If you need treatment, an EWC Primary Care Provider (EWC PCP), can also help you enroll into the DHCS Breast and Cervical Cancer Treatment Program.

To determine your eligibility for EWC Program covered services, all sections of this application must be completed. An applicant must be enrolled into the EWC Program before the program can pay for any program covered services. If an applicant is found eligible for the EWC Program, enrollment will be for one year, from the time a signature and date is provided on this application. After one year, if the applicant wants to continue to receive EWC free breast and cervical cancer screening and diagnostic services, they must re-enroll with an EWC PCP.

An EWC PCP, the PCP Clinic Staff or an authorized person acting on your behalf may help you complete this application.

- Pages 1, 2, and 3 are for you (the EWC Applicant) to read and keep.
- Pages 4, 5, and 6 must be completed to determine if you are eligible.
- Pages 7, 8, and 9 are *Form Instructions for your use* to complete pages 4, 5, and 6.
- Pages 10-12 are completed and kept by an *EWC PCP for Internal use*.

Privacy Statement

This application will assist in determining your eligibility to receive EWC Program covered services. It is your choice to complete this application. If the application is not completed, the EWC program may not be able to determine if you qualify for services and the program may contact you. You have the right to access your records. Your medical records can contain personal information. For more information, and/or to review your records, please contact the EWC Program at:

Department of Health Care Services
Benefits Division/Every Woman Counts Program
Attention: Division Chief
P.O. Box 997417, MS 4601
Sacramento, CA 95899-7417
(916) 449-5300

Revenue and Taxation Code sections 30461.6(f) and (j), and Health and Safety Code sections 104150(b), 104162, and 131085 authorize the EWC Program to keep the information collected on this application. We must give you this Privacy Statement under Civil Code section 1798.17.

First Level Review and Formal Hearing Rights for the Every Woman Counts Program

You will be informed by the EWC Program if you are or are not eligible to participate in the program. If you do not agree with the eligibility decision, you have the right to ask for a First Level review and/or a formal hearing. In addition, you have a right to a First Level review and/or formal hearing if you disagree with the EWC Program covered services you are receiving.

You may not challenge the EWC Program eligibility criteria, used to make your eligibility decision. For example, if you think that the decision did not match the EWC Program eligibility criteria, you may ask for a First Level review and/or a formal hearing. But if you disagree with the EWC program eligibility criteria, you may not ask for a first level review and/or formal hearing to try to change the EWC program eligibility criteria. The EWC eligibility criteria is available online.

If you wish to exercise your right to ask for a First Level Review and/or a formal hearing, please submit a written request that includes the following:

- Your name, address, and telephone number.
- The reason why you are requesting a first level review and/or formal hearing.
- Why you believe the decision is wrong.
- Your language preference if you have trouble understanding English.
- The name, address, and telephone number of your authorized representative if you choose to use one.

First Level Review: The written request for a first level review must be sent to the EWC program within 20 days of the decision that you disagree with. Please keep a copy of your written request for your records. The EWC program will respond within 30 days of receipt of your request.

Mail your request for a First Level Review
Department of Health Care Services
Benefits Division/Every Woman Counts Program
Attention: Division Chief
P.O. Box 997417, MS 4601
Sacramento, CA 95899-7417

OR

Email your request for a First Level Review to:
CancerDetection@dhcs.ca.gov

The EWC program may contact you for more information. This contact may be by phone, writing and/or electronically. An EWC PCP may also be contacted for information.

Formal Hearing: The written request for a formal hearing must be sent to the Department of Social Services within 90 days of the decision you disagree with. If you have good cause why you were not able to file for a formal hearing within 90 days, you may still ask for a formal hearing to be scheduled. Please keep a copy of your written request for your records.

Mail your request for a Formal Hearing
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-442
Sacramento, California 94244-24

Notice of Non-discrimination

DHCS complies with federal and state civil rights laws. DHCS does not unlawfully discriminate based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

To communicate effectively, DHCS

- Provides appropriate aids and services for qualified persons with disabilities, this includes:
  - Qualified sign language interpreters
  - Documents in braille, large print, audio, and electronically.
  - Communications accessible to people who have speech, hearing, or vision impairments.
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need the services mentioned above, please contact the DHCS Office of Civil Rights, at (916)440-7370, #711 (California State Relay) or email CivilRights@dhcs.ca.gov.

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Tell us about You

[1]First Name _____ [2]Middle Initial _____ [3]Last Name _____

[4]Date of Birth (MM/DD/YYYY) _____

[5]What is your sex? (check one)
☐ Female ☐ Male
☐ Transgender (male to female) ☐ Transgender (female to male)

[6]Your Mother's Last Name at birth (Maiden Name) _____

[7]Address _____

[8]City _____ [9]State _____ [10]Zip Code _____

[11]Telephone number [(area code) number] _____

[12]Email address _____

[13]Social Security Number (List if you have one) _____

Tell us about your Family/Household and Total Income.
The following information helps us decide of you are eligible for the EWC Program.

We need to know how much money everyone in your family/household receives before paying taxes. If you file taxes, this is your "gross income" (before taxes and other deductions).

[14]What is the total number of persons living in your family/household? _____

[15]What is the total income of your family/household $ _____

Now let us know about your health insurance

☐ [16]I do not have health insurance.

☐ [17]I have health insurance or a healthcare plan but cannot afford the share-of-cost, deductible, or co-pay.

What EWC services do you need? (Check all that apply)

☐ [18]Are you 21 years or older and want to be screened for cervical cancer?

☐ [19]Are you 40 years or older and want to be screened for breast cancer?

☐ [20]Do you have symptoms in your breast(s) and want further testing?

Please check what are the symptoms in your breast(s) below:

☐ [21]A change in the look or feel of your breast(s), such as change of color, size, or shape

☐ [22]Swelling or thickening of your breast(s) tissue

☐ [23]Discharge from your nipple

☐ [24]Lump or hard knot in your breast(s)

☐ [25]Inverted Nipple

☐ [26]Breast or Nipple Pain

☐ [27]Other: _____

Tell us about your use of tobacco

[28]Do you smoke tobacco now? ☐ No ☐ Yes

[29]Do you use other tobacco products now? ☐ No ☐ Yes. Please Explain: _____

Tell us about your race (Optional and Confidential): Please select all that apply to you. The following information will NOT be used to decide your EWC Program eligible.

☐ [30]Hispanic or Latina

☐ [31]American Indian or Alaskan Native

☐ [32]Asian (Specify below)

- ☐ [33]Asian Indian ☐ [34]Cambodian ☐ [35]Chinese ☐ [36]Filipino
- ☐ [37]Hmong ☐ [38]Japanese ☐ [39]Korean ☐ [40]Laotian
- ☐ [41]Vietnamese ☐ [42]Other Asian: _____

☐ [43]Black or African American

☐ [44]Pacific Islander (Specify below)

- ☐ [45]Guamanian ☐ [46]Hawaiian ☐ [47]Samoan ☐ [48]Other Pacific Islander: _____

☐ [49]White

☐ [50]Other: _____

☐ [51]Prefer not to answer

Tell us about your Gender Identity and Sexual Orientation (Optional and Confidential). The following information will NOT be used to decide your EWC Program eligibility.

What is your gender? (check the box that best describes your current gender identity).

☐ [52]Female ☐ [53]Male

☐ [54]Transgender (male to female) ☐ [55]Transgender (female to male)

☐ [56]Non-Binary (neither female nor male)

☐ [57]Another Gender Identity _____

What Sex is listed on your original birth certificate? ☐ [58]Female ☐ [59]Male

What do you think of yourself as?

☐ [60]Straight or heterosexual ☐ [61]Lesbian or Gay ☐ [62]Bisexual

☐ [63]Queer ☐ [64]Another Sexual Orientation: ☐ [65]Unknown

_____

Every Woman Counts Program – Recipient Enrollment Application

Declarations (Please read carefully and initial each item)

_____ [66]I understand that by signing and dating this application, either in person, verbally, or electronically, I am applying to the EWC Program (a government-funded program).

_____ [67]I consent to receive free breast and/or cervical cancer screening and diagnostic services provided the EWC Program.

_____ [68]I understand that this agreement lasts for ONE YEAR from the date I sign this application. I must complete a new application each year to be in enrolled into the EWC Program.

_____ [69]I understand I can stop participating in the EWC Program at any time.

_____ [70]I will let the EWC PCP know right away, if there are any changes to my health insurance information and/or other medical coverage.

_____ [71]I received and read the DHCS Notice of Privacy Practices (separate form).

_____ [72]I have received the First Level Review and Formal Hearing Rights, and Notice of Nondiscrimination (provided on pages 1, 2, and 3 of this application).

_____ [73]I have received information on how to receive free or low-cost health insurance (separate form).

_____ [74]I declare under penalty of perjury under State of California law that the information I have provided on this application is true and correct to the best of my knowledge. I understand that giving false information on this application can affect my eligibility to receive cancer prevention services through the EWC Program.

[75] Your Signature _____ Date _____

Was the applicant signature authorized through verbal consent? ☐ No ☐ Yes

[76]If a person is acting on your behalf, (PRINT) Name, relationship to you and today's date.

Name _____ Relationship _____ Date _____

[77]If a person is acting on your behalf, is the PCP or PCP Clinic Staff (PRINT) Name, Position/Title, and the date.

Name _____ Position/Title _____ Date _____

[78]Signature of Person Acting on your behalf:

Signature _____ Date _____

Every Woman Counts Program – Recipient Enrollment Application

DETAILED FORM INSTRUCTIONS FOR COMPLETING THIS EWC RECIPIENT APPLICATION (PAGES 7 THROUGH 9)

Tell us about you

1. Write your First Name.
2. Write the first letter of your Middle Name.
3. Write your Last Name.
4. Write your birthdate. Use 2 numbers for the month, 2 numbers for the day, and 4 numbers for the year. For example, January 1, 2001, would be 01/01/2001.
5. If your physical sex is female: check female, or if male: check male. If, you are transgender male to female: check transgender (male to female). If it is transgender female to male: check transgender (female to male).
6. Write your mother's maiden name. This is her original last name when she was born.
7. Write the street number, and name of where you live. For example, 123 Main Street.
8. Write the city you live in.
9. Write the state you live in.
10. Write the zip code for where you live.
11. Write your telephone number. Begin with a three-digit number for area code, followed by an 8-digit phone number.
12. Write your email address.
13. Write your Social Security Number (SSN) if you have one. Your SSN will not determine your eligible.

Tell us about your Family/Household and Gross Income

14. Write down the total number of persons living in your Family/Household. A Family/Household is a group of two or more persons who are related by birth, marriage, or adoption and who live together. EWC uses the U.S. Health and Human Services (HHS), Federal Poverty Guidelines, for income eligibility to calculate your poverty level. All EWC recipients must have a Family/Household income at or below 200 percent of the HHS Federal Poverty Guidelines.
15. Write down the total amount of money that your Family/Household receives (before taxes and other deductions are applied). Your Family/Household includes the total number of persons you entered on line 14 that are living on this total amount of money.

Now let us know about your health insurance

16. Check this box if you do not have any health insurance.
17. Check this box if you do have health insurance, or a healthcare plan but cannot pay a share of cost, deductible, and or a co-pay.

What EWC services do you need (Check all that apply)

18. Check this box if you are 21 years of age, or older and want to be screened for cervical cancer.
19. Check this box if you are 40 years of age, or older and want to be screened for breast cancer.
20. Check this box if you have symptoms in your breasts and want to receive breast cancer screening services.
21. Check this box if your breast(s) size, color, or shape has changed.
22. Check this box if there is any swelling or thickening of your breast(s) tissue.

23. Check this box if there is any discharge from your nipple.
24. Check this box if there is a lump or hard knot in your breast(s) that you can feel.
25. Check this box if you have an Inverted Nipple
26. Check this box if you are experiencing Breast or Nipple Pain
27. Check this box if your breast(s) have other symptom(s). Write down your symptom(s).

Tell us about your use of tobacco

28. If you do not smoke tobacco now, check NO box. If you do smoke tobacco, check YES box.
29. If you do not use other tobacco products, check No box. If you do use other tobacco products, check Yes box, and write what tobacco products you use.

Tell us about your race

30. Check this box if, your race is all or part Hispanic or Latina.
31. Check this box if, your race is all or part American Indian or Alaskan Native.
32. Check this box if, your race is all or part Asian.
33. Check this box if, your race is all or part Asian Indian.
34. Check this box if, your race is all or part Cambodian.
35. Check this box if, your race is all or part Chinese.
36. Check this box if, your race is all or part Filipino.
37. Check this box if, your race is all or part Hmong.
38. Check this box if your race is all or part Japanese.
39. Check this box if, your race is all or part Korean.
40. Check this box if, your race is all or part Laotian.
41. Check this box if, your race is all or part Vietnamese.
42. Check this box if, your race is all or part another Asian race. Write your race.
43. Check this box if, your race is all or part Black or African American.
44. Check this box if, your race is all or part Pacific Islander and please specify.
45. Check this box if, your race is all or part Guamanian.
46. Check this box if, your race is all or part Hawaiian.
47. Check this box if, your race is all or part Samoan.
48. Check this box if, your race is all or part Pacific Islander and please specify other.
49. Check this box if, your race is all or part White.
50. Check this box if, your race is all, or part of a race not listed. Write your race.
51. Check this box if, you do not want to state your race.

Tell us about your Gender Identity and Sexual Orientation (Optional and Confidential)

52. Check this box if, you identify as a female.
53. Check this box if, you identify as a male.
54. Check this box if, you identify as a female but were identified as a male at birth.
55. Check this box if, you identify as a male but were identified as a female at birth.
56. Check this box if, your gender identity is non-binary (neither female nor male).
57. Check this box if applicable, and list another gender identify.
58. Check this box if, you were born female.
59. Check this box if, you were born male.

60. Check this box if, your sexual orientation is straight or heterosexual (sexually attracted to people of the opposite sex).
61. Check this box if, your sexual orientation is Lesbian or gay (sexually attracted to people of the same sex as you).
62. Check this box if, your sexual orientation is bisexual (sexually attracted to both male and female).
63. Check this box if, your sexual orientation is queer (not exclusively heterosexual).
64. Check this box if applicable and write another sexual orientation.
65. Check this box if, you do not know your sexual orientation.

Declarations, Completed application and Patient Consent: Initials and Signatures

66. Read the sentence and write your initials on the line. You are indicating your understanding that you are applying for program eligibility, to participate in the EWC Program.
67. Read the sentence and write your initials on the line. You are indicating that you consent to receive, free EWC Program breast and cervical cancer screening and diagnostic services.
68. Read the sentence and write your initials on the line. You are indicating that you understand this agreement to participate, in the EWC Program, lasts one year from the time you SIGN and DATE this application. You must complete a new application each year after a 12-month period.
69. Read the sentence and write your initials on the line. By initialing you understand that you can stop participating in the EWC Program at any time.
70. Read the sentence and write your initials on the line. You are indicating that you will let your EWC PCP know right away if there are any changes to your health insurance or other medical coverage.
71. Read the sentence and write your initials on the line. You are indicating you have received a DHCS Notice of Privacy Practices (NPP is a separate form).
72. Read the sentence and write your initials on the line You are indicating that you have received information on the First Level Review and Formal Hearing Rights, and Notice of Non-discrimination (indicated on pages 1, 2, and 3 of this application).
73. Read the sentence and write your initials on the line. You are indicating that your EWC PCP has informed you, on how to get free or low-cost health insurance.
74. Read sentences 66 through 74 and write your initials on each line. You are declaring that the information provided on this application is true and correct to the best of your knowledge. You also understand that giving false information, on this application, can affect your eligibility to receive breast and cervical cancer screening and diagnostic services through the EWC Program.
75. Write (SIGNATURE and DATE) your name and today's date. If the applicant provides verbal consent, PCP and/or Clinic Staff needs to write (PRINT) applicants name and Check NO or YES.
76. Write (PRINT) the name, date, and relationship of the person who is authorized to act on your behalf and is assisting you with completing this application.
77. Write (PRINT) the name of the PCP, or PCP Clinic Staff (include Position/Title), and date, of the person who is acting on your behalf and is assisting you with completing this application.
78. Write (SIGNATURE) of the person from line 77 or 78 and write today's date. FOR EWC Primary Care Provider (PCP)

Every Woman Counts Program – Recipient Enrollment Application

FOR EWC Primary Care Provider (PCP)

FOR INTERNAL USE ONLY (PAGES 10 Through 12)

If obtaining verbal consent complete each field of the application, on behalf of the applicant, based on the applicant's verbal responses. Ask that the individual/Authorized Representative verbally acknowledge their consent.

☐ 1. EWC Applicant Name (PRINT) _____

☐ 2. Medical Record Number _____

☐ 3. Recipient ID _____

ELIGIBILITY CRITERIA

Residency

☐ 4. Lives in California

Household Income

☐ 5. Family/Household Income is at or below 200 percent of the HHS Federal Poverty Guidelines.

Health Insurance

☐ 6. Is uninsured ☐ 7. Can NOT pay a share of cost, deductible, and or co-pay.

EWC program services

☐ 8. Needs breast cancer diagnostic services for, a symptomatic EWC applicant at any age.

☐ 9. Needs breast and/or cervical cancer screening, at the recommended age for the service(s)

I have provided this EWC program applicant with the following information:

☐ 10. I have provided the EWC applicant with a DHCS Notice of Privacy Practices

☐ 11. I gave the EWC applicant a DHCS First Level Review and Formal Hearing Rights, and Notice of Nondiscrimination

☐ 12. I provided the EWC applicant with information about how to obtain free and low-cost health insurance.

Eligibility Determination:

☐ 13. I determined the EWC applicant meets ALL EWC program eligibility requirements.

☐ 14. I determined the EWC applicant does NOT meet EWC Program eligibility requirements.

Tobacco Use (if eligible for EWC)

☐ 15. The PCP assessed the applicants' tobacco use and status:

- ☐ I determined the applicant USES tobacco products and referred them to appropriate smoking cessation resources. I ensured that the YES box is checked.
- ☐ I determined the applicant does NOT smoke tobacco, and if applicable the No box is checked.
- ☐ If the applicant does use tobacco products, I determined what specific products are used. I ensured that the specific tobacco products used were written down.

☐ 16. Lines 76, 77, and 78 have been printed or signed and dated. (Pages 6 and 11)

- ☐ Write the applicants name and date on signature line 75 (Page 6)
- ☐ Determine if the applicant's signature was authorized through verbal consent and check YES or NO Boxes included in line 75 (Page 6).
- ☐ If applicable and you are the PCP Clinic Staff, PRINT your name, Position/Title, and date on line 76 and 17 (Page 6 and 11)
- ☐ If you are a PCP, write (PRINT and SIGN) your name and date on line 78 and line 19 (Page 6 and 11).

☐ 17. If applicable, (Print) PCP Clinic Staff Name (Include Position/Title) on line 76 and line 17.

Name _____ Position/Title _____ Date _____

☐ 18. I have obtained all the appropriate printed names, signatures, titles (if applicable) and dates for this EWC applicant to begin determining program eligibility and consent, to receive EWC clinical services. This includes Signatures and dates provided on lines 76, 77, and 78 (Page 6).

☐ 19. EWC PCP SIGN and DATE this DHCS 8699 Form to confirm eligibility (Page 11 of 12).

PCP/Staff Signature _____ Date _____

☐ 20. Place and maintain a copy of the application in the EWC Applicant/Recipient Medical File.

EWC Program Applicant Information

1. Check this box if, you write the EWC applicant name (First, Middle Initial, Last).
2. Check this box if, you write the EWC applicant Medical Record Number.
3. Check this box if, you write the EWC applicant assigned Recipient ID.
4. Check this box if, the EWC applicant lives in California.
5. Check this box if, the EWC applicant's Family/Household income is at or below 200 percent of the Federal Poverty Guidelines. This is based on the number of persons in the Family/Household. Current Health and Human Services, Federal Poverty Guidelines are located on the EWC website: https://dhcs.ca.gov/EWC
6. Check this box if, the applicant is uninsured (does not have health insurance).
7. Check this box if, the EWC applicant is underinsured, has health insurance or a healthcare plan, but cannot pay a share of cost, deductible, and/or a co-pay.
8. Check this box if, the EWC applicant has breast cancer symptoms and needs diagnostic services.
9. Check this box if, the EWC applicant is age 21 years or older and needs cervical cancer screening and diagnostic services. Or if the EWC applicant is age 40 or older and needs breast cancer screening and diagnostic services.
10. Check this box if, you provided a DHCS Notice of Privacy Practices to the applicant.
11. Check this box if, you gave the EWC applicant a Notice of Privacy Practices statement, First Level Review and Formal Hearing Rights, and Notice of Nondiscrimination.
12. Check this box if, you gave the EWC applicant information about how to obtain free and low-cost healthcare insurance.
13. Check this box if, the EWC applicant meets all the EWC Program eligibility criteria.
14. Check this box if, the EWC applicant does not meet all the EWC Program eligibility criteria.
    a. Advise the EWC applicant if they are not eligible to receive EWC Program covered services, and that they may appeal decision.
15. Check this box if, the applicant is eligible for the EWC Program, check this box if the PCP discussed tobacco use with the applicant.
16. Check this box if, you signed your name and provide today's date. Print your full name on the next line.
17. Check this box if, you have obtained the appropriate signatures, data, and recipient consent to determine that this EWC program recipient is eligible to enroll into the EWC Program and received program covered services.
18. Check this box to indicate that you have obtained all required signatures, dates, titles (if applicable), and EWC applicant consent. An EWC applicant's written signature, and date must be provided and documented, in person, verbally or electronically by the applicant or authorized person acting on behalf of the EWC applicant, as indicated on lines 76 and 77 (Page 6).
19. Check this box if, you have included a PCP/Staff Signature and date on (Page 11 of 12).
20. Check this box if, you have placed and maintained a copy of this application in the EWC Applicant Medical File.