State of California Department of Health Care Services

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

***FOR PROVIDER/OFFICE USE ONLY* (Rev. 12/2019)**

This checklist is to assist Every Woman Counts (EWC) & Family Planning Access, Care, and Treatment (FPACT) Enrolling Providers in determining if an individual is eligible to submit an application for a BCCTP program.

☐ **1) Is this individual a California resident with the intent to stay?**
No = cannot apply; Yes = continue to #2

☐ **2) Does this individual have gross income at or below the 200% FPL?**
No = cannot apply; Yes = continue to #3

- See the EWC or FPACT Income Criteria chart.
- All earned and unearned income (before any taxes, deductions, or expenses) is counted.
- Total number of persons counted in the household are applicant, spouse, and children under 21.
- If the child is not the biological child, applicant must be able to produce a legal document stating they are now responsible for the child.
- The income of elderly parents or relatives living in the home is not counted towards the applicant's income; they are also not counted in the household number regardless of inclusion for tax reporting.

☐ **3) Does this person have a BCCTP qualifying diagnosis?**
No = cannot apply; Yes = continue to #4

- After log-in, see list of qualifying diagnoses on the drop down menu in the BCCTP on-line application.
- If a diagnosis is not on the drop-down list or is unclear, you may fax the pathology report to (916-440-5693) with questions or email the pathology report to BCCTP@dhcs.ca.gov, requesting to have the pathology report reviewed by a Medical Consultant. A BCCTP Eligibility Specialist will contact you with a response.

☐ **4) Does this person already have full scope Medi-Cal benefits?**
Yes = cannot apply; No = continue to #5

- Individuals who have restricted scope emergency and pregnancy benefits, or Share of Cost (SOC) Medi-Cal benefits, are eligible to apply for BCCTP.

☐ **5) Does this person have private insurance or Medicare? Yes/No = Can Apply**

- Individuals with private insurance or Medicare are eligible to apply for BCCTP if they meet the first four (4) requirements listed above.

Submit an application only if the applicant meets the requirements in Questions 1 - 4.

Note: *If a provider does not elect to process a BCCTP application for an individual that was screened elsewhere, refer the individual to apply for Medi-Cal in order to be referred to BCCTP. If the individual already has restricted or SOC Medi-Cal, they should contact their county eligibility worker and request to be referred to BCCTP. BCCTP will not accept county referral documents directly from the beneficiary or any medical provider.*

Prior to contacting BCCTP, please check the Medi-Cal database (MEDS) after 10 working days from application submission for case status.

Important information about Presumptive Eligibility (PE)

Not all individuals will get immediate PE benefits. All applications submitted to BCCTP are considered for Federally-funded PE benefits. These benefits are temporary and date specific. PE benefits are approved until the end of the month following the application month. All applicants must apply for Medi-Cal in order to extend their benefits. Once the application is submitted to the county (via Internet, phone, or in-person), their PE benefits continue until the county completes a determination. Date specific means, that if continuing BCCTP benefits are denied, the eligibility is from the date applied to the date denied. Applicants determined eligible for PE will not receive benefits prior to their application date. Applicants denied PE benefits are evaluated for the BCCTP State-funded programs.

☐ If the applicant is approved for PE, inform them that they can get immediate care by using their confirmation document with their Beneficiary Identification Card number.

☐ Make the applicant aware of the requirement to apply for Medi-Cal and provide the "Directions to Apply for Medi-Cal" document. PE benefits will terminate the end of the month following the date their BCCTP application was submitted.

☐ Applicants meeting one or more of the following criteria will **not** receive Federally-funded PE benefits. Their completed/signed application should be forwarded to the BCCTP for evaluation for State-funded BCCTP benefits.

- Age 65 or older.
- Have other comprehensive coverage (Medicare, or private insurance).
- Have received PE benefits within the last 12 months (hospital emergency or pregnancy).
- Are already identified in the Medi-Cal database as having unsatisfactory immigration status.

☐ Inform the applicant that they are not guaranteed State-funded BCCTP benefits until the final BCCTP determination is processed.

BCCTP Requirement: Applying for Medi-Cal

ALL applicants that have not had a Medi-Cal determination within the last 30 days must apply for and receive an eligibility decision before BCCTP will make a final determination.

- Applicants that currently have active restricted scope Medi-Cal do not need to reapply.
- Enrolling Providers should not wait until the county makes a decision to submit a BCCTP application.
- Do not send individuals to apply for Medi-Cal if they did not meet the first four (4) requirements as indicated on the opposite page.

Note: *If you have any questions or require corrections to the application after submitting, please contact BCCTP via email (BCCTP@dhcs.ca.gov), or fax (916) 440-5693; BCCTP will make all edits/corrections. Do not submit multiple applications for the same person, unless a BCCTP staff has instructed you to do so.*

THE BREAST AND CERVICAL CANCER TREATMENT PROGRAM
MEDI-CAL APPLICATION WORKSHEET

Please answer the following questions in English, whenever possible.

1. This is a Medi-Cal application for immediate health care services for this month and next month. Do you also want to use this application to get continuing Medi-Cal coverage? Yes No (Circle one)

   This application does not contain enough information for a determination if you are eligible under any other Medi-Cal program. This application will be used to determine if you are eligible for Medi-Cal under BCCTP rules only. If you think you are eligible for Medi-Cal for other reasons besides your breast or cervical pre-cancerous/cancer diagnosis, please contact your county social services office and submit a full Medi-Cal application. You have a right to file an application at your local county social services office to determine if you are eligible for any other Medi-Cal program.

2. Have you had medical expenses within the 3 months before the month you applied for the BCCTP and do you want Medi-Cal for those expenses? Yes No (Circle one)

State of California Benefits Identification Card:

3. Do you have a State of California Benefits Identification Card? Yes No (Circle one)

4. Please list BIC # (If available) _____

Identification Information:

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

5. Last Name: _____

6. First Name: _____

7. Middle Name: _____

8. Appellation: _____

9. Social Security Number: _____

   A Social Security Number is required for full Medi-Cal 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 and emergency services without a Social Security Number.

10. Gender: Male Female (Circle one)

11. Date of Birth: _____

12. Place of Birth: _____
    County of Birth: (If California) _____
    State of Birth: (If Not California County) _____
    Country of Birth: (If Not USA) _____

See next page

U.S. Citizen, National or a naturalized citizen? Yes No (Circle one)

Immigrants who meet all immigration requirements may get continuing full Medi-Cal benefits. Undocumented immigrants can get Breast and Cervical Cancer treatment and emergency services.

13. Ethnicity: (Optional) _____

Address Information:

You must be a resident of the State of California. If you are homeless check here. Complete Residence Address section (general street location should be entered in Street Address).
Also, complete the Mailing Address Section. ☐

14. Residence Address:
    C/O: _____
    Street Address: _____
    City: _____
    State: _____
    Zip Code: _____
    County of Residence: _____

15. Mailing Address: (If different)
    C/O: _____
    Street Address: _____
    City: _____
    State: _____
    Zip Code: _____
    County of Residence: _____

16. Contact Information:
    What is the best way to contact you? _____
    Email Address: _____
    What is the best time to call? _____
    Phone Number 1: _____
    Phone Number 2: _____
    Phone Number 3: _____
    Spoken Language: _____
    Written Language: _____

Medicare Coverage Information:

17. Do you have Medicare Part A (Inpatient)? Yes No (Circle one)

18. Do you have Medicare Part B (Outpatient)? Yes No (Circle one)

See next page

19. Are you enrolled in a Medicare HMO? Yes No (Circle one)

20. Do you have Medicare Part D (Prescription Drug)? Yes No (Circle one)

21. Health Insurance Claim Number: _____

Other Health Insurance Information:

22. Do you have other comprehensive medical coverage? Yes No (Circle one)

23. If Yes, identify Health Insurance Carrier(s): _____

24. Primary Subscriber/Member Number: _____

25. Do you have any co-pays, premiums, or deductibles? Yes No (Circle one)

See next page

Medi-Cal Confidentiality Notice

The information given in this application is private and confidential under Welfare and Institutions Code 14100.2.

The information will be disclosed only in accordance with those laws.

Medi-Cal Rights, Responsibilities and Declarations

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I request on-going Medi-Cal and think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days of the date the Notice of Action (NOA) was mailed to me. To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.
- Review Medi-Cal program rules and manuals.

I have the responsibility to:

- Report any changes within 10 days in the information I give on this application.
- Let local welfare office know if a family member, who also has Medi-Cal, applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.
- Assignment of rights to medical support to the State of California.
- Assign rights to third party medical support to the State of California.

I understand that:

- As a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.
- Persons I am applying for are not in jail, prison, or any other correctional facility.
- After my death, the State has the right to seek repayment from my estate for all Medi-Cal benefits I receive after age 55 unless I have a surviving spouse, minor child(ren), blind or permanently and totally disabled child(ren).
- If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.

Medi-Cal Privacy Notice
The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Care Services to provide the following information:

Welfare and Institutions Code Section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application.

This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) The information will be used to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1137(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for only breast and cervical cancer and emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Care Services.

Contact your local welfare office to request your records if you are not covered by the Breast and Cervical Cancer Treatment Program.

Please include this form with the signed formal application and mail to:
Dept. of Health Care Services, Medi-Cal Eligibility Division, B.C.C.T.P., MS 4611,
P.O. Box 997417, Sacramento, CA 95899-7417

NAME	APPLICATION TRACKING NUMBER

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 wants Medi-Cal when the person is incompetent, in a comatose condition, or suffering from amnesia and there is no spouse, conservator, guardian or executor
- Persons 14 to 21 years old who are not living with their parent, caretaker relative or foster parent and who are applying for themselves

For information about any of the following programs, check the box(es) below and information will be sent to you. See the Medi-Cal website, www.dhcs.ca.gov

☐ Personal Care Service Program (PCSP). A program for in-home care.

☐ Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

☐ Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

☐ Family Planning.

☐ Child Health and Disability Program (CHDP). Preventive healthcare for children and youth.
Do you want your children or youth referred to the CHDP program? ☐ Yes ☐ No

SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, and the documents given are correct and true to the best of my knowledge and belief.

I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature	Date
Witness Signature (If person signed with a mark)	Date

Signature of person helping Applicant fill out the form	Telephone Number	Relationship to Applicant	Date
Signature of person acting for Applicant/Beneficiary	Telephone Number	Relationship to Applicant	Date

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