Ohio Breast and Cervical Cancer Project
Client Enrollment Form

Today's Date:		Enrollment Site:	
Last Name:	First:	MI	Maiden:
Email Address:			

Address		City	
County		State	Zip
Home Phone	Cell Phone	Date of Birth	Age today years
Social Security number	Ethnicity (check one) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	Race (check all that apply) ☐ White ☐ Black ☐ Asian ☐ American Indian	

Optional (used for program evaluation only) – check all that apply

☐ Amish ☐ Mennonite ☐ LGBTQ ☐ A woman with a disability

Number of people in household: _____ (Spouse, dependent children)

Are you married? ☐ Yes ☐ No If yes, what is your spouse's name? _____

How much money do you, and members of your household listed above make or receive <u>before taxes</u>?

$_____ per week or $_____ per month or $_____ per year

Income includes salary and wages, tips, alimony, public assistance, disability, unemployment, Social Security, SSI, interest, retirement and pension.

What medical coverage do you have now? (check all that apply)

☐ No Insurance ☐ Medicaid ☐ Medicare Part B
☐ Medicare Part A ☐ Private insurance or HMO ☐ Other – Disability, cancer policy, etc.

How did you hear about the Breast and Cervical Cancer Project for this enrollment? (check one)

☐ My own research ☐ Friend or relative told me ☐ On TV, radio or newspaper
☐ BCCP reminder ☐ My doctor told me ☐ Social Media (Facebook, Instagram, etc.)
☐ Internet (website, search engine, etc.) ☐ Other organization (Komen, community agency, etc.)
☐ Read a brochure, flyer or poster ☐ Heard a speaker at (where) _____
☐ Other (please describe) _____

Medical Background

Have you ever had a mammogram? ☐ Yes ☐ No Date of last mammogram: _____
Have you ever had a pap test? ☐ Yes ☐ No Date of last pap test:_____
Do you use tobacco? ☐ Yes ☐ No

Thank you for completing the enrollment form for the Ohio Breast and Cervical Cancer Project. A staff member will be contacting you.

Submit form to BCCP **Clear Form**

For office use only

40 or older?	☐ **Yes** ☐ **No**	☐ **Enroll in BCCP Direct Services?**	
Uninsured?	☐ **Yes** ☐ **No**	☐ **Enroll in Patient Navigation Services?**	
Within 200% of FPL?	☐ **Yes** ☐ **No**		