

APPLICATION FOR SOUTH CAROLINA MEDICAID

Breast and Cervical Cancer Program

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to provide full Medicaid benefits to uninsured women who are found to be in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia). This coverage group is known as the Breast and Cervical Cancer Program (BCCP).

A woman diagnosed and found in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia) can qualify for Medicaid coverage if the following criteria are met:

- The applicant has been screened for breast or cervical cancer, diagnosed and found in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia);
- She is an adult under age 65;
- She must meet SC state residency, citizenship/alienage, and identity requirements;
- She does not have other insurance coverage that would cover treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia), including Medicare Part A or B;
- Her family income is at or below 200% of the Federal Poverty Level; and
- She is not eligible for another Medicaid eligibility group.

Application process

Upon being diagnosed with breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia) a woman can apply for coverage in the following manner:

1. Complete and sign the Breast and Cervical Cancer Program application.
2. The provider rendering the diagnosis must complete and sign Section I of the application.
3. The completed application is faxed to the Breast and Cervical Cancer Program at (803) 255-8223. A Pathology Report indicating the diagnosis and a copy of the applicant's insurance card must be faxed with the application. Note: A cytology report (Pap Smear) is not sufficient.
4. The applicant will be notified in writing of approval or denial of the application. Women who qualify are eligible for the full range of Medicaid coverage.
5. Coverage continues as long as eligibility criteria are met and the beneficiary continues treatment. The beneficiary must report to her Medicaid worker when treatment is completed.
6. Eligibility is reviewed annually for women with breast or cervical cancer and bi-annually (every six months) for women with pre-cancerous lesions. When it is time for the review, a review form is mailed to the beneficiary and must be returned or coverage will stop.
7. Once treatment is completed, the beneficiary must qualify under another Medicaid program for coverage to continue.

If you have questions regarding the BCCP, or need help in completing the application, please call: 1-888-549-0820 (toll-free).

Medical providers can order additional copies of this application from forms@dhhs.state.sc.us.

APPLICATION FOR SOUTH CAROLINA MEDICAID - Breast and Cervical Cancer Program

Section I – To be completed by the Medical Provider – *Please print.*

Is this a Best Chance Network (BCN) patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	BCN Screening Provider Site:	Date of BCN Screening:
Provider Referring Patient to Medicaid:	Address:	Telephone: () Fax: ()
Has the patient been diagnosed and requires treatment for? <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Atypical Breast Hyperplasia <input type="checkbox"/> Precancerous Cervical Lesions (CIN 2/3)		Date of Diagnosis: (Attach Pathology Report.)
Has the patient received treatment for this diagnosis in the past 3 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the patient have insurance coverage for these expenses?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient in need of continued treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Person Completing Section I: _____ Telephone: () _____ Date: _____		

Section II – To be completed by the Applicant - *Please print.*

1. Name (First, Middle, Last)		2. Full Name at Birth (First, Middle, Last)	
3. Age	4. Date of Birth	5. Place of Birth (City, County, State)	
6. U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, you must provide proof of citizenship.</i>	7. Social Security Number	8. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
9. Street Address _____ City _____ State _____ Zip Code _____	10. Mailing Address _____ City _____ State _____ Zip Code _____		
11. County	12. Telephone Number ()	13. Mother's Maiden Name (First, Middle, Last)	
14. Tell us about any health insurance you have, including Medicare Part A or B. We need a copy of the insurance card.			
Insurance Company	Policy/Medicare Number	Policy Holder's Name	Policy Holder's SSN
15. Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Mexican <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Refugee Entrant <input type="checkbox"/> Other			
16. Tell us what language you use : <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese			
17. Total family yearly income (before taxes): \$ _____ Family size (including applicant): _____			
18. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, attach verification from a medical provider.)</i> Delivery Due Date: _____			
19. Are you totally and permanently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. Do you receive SSA disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Are you responsible for children under age 19 in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**If the answer to questions 18, 19, 20 and 21 is NO, you may now sign the application and STOP.
If the answer to questions 18, 19, 20 or 21 is YES, you may be eligible for Medicaid under another program.
You must complete the information on page 3, then sign below.**

I have read my Rights and Responsibilities on Page 4. Yes No

Applicant's Signature: _____ Date: _____

DHHS Use Only

FAMILY SIZE: _____ INCOME LIMIT: _____ FAMILY INCOME: _____

SCDHHS, Breast and Cervical Cancer Program, Division of Central Eligibility Processing
PO Box 100101, Columbia, South Carolina 29202; Fax (803) 255-8223
If you have questions or need help completing this application, call 1-888-549-0820

22. List the adults and children who live with you. Social Security Numbers are not required for persons who are not applying for Medicaid. If you tell us the Social Security Numbers, it may help us process your application faster.

Name (First, Middle, Last)	Relationship to You	Birthdate Mo/Day/Yr.	Social Security Number	Race	Sex	US Citizen?	
						Yes	No

Income

23. Does anyone in your household work? Yes No

Name of Person Who Works:	Name of Person Who Works:
Employer Name and Telephone Number: _____	Employer Name and Telephone Number: _____
Amount Earned Each Pay Period Before Taxes \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	Amount Earned Each Pay Period Before Taxes \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly

Tell us how much other income your family has: *(Attach additional pages if necessary.)*

Other Income	Amount	How Often Do You Get This Income?	Which Family Member Gets This Income?
Child support	\$ _____		
Alimony	\$ _____		
Social Security payment	\$ _____		
Unemployment benefits	\$ _____		
Other (Please explain.)	\$ _____		

- **Please send Proof of Income.** Send copies of pay stubs for the last 4 weeks or a letter from your employer. If self-employed, please send a copy of your most recent Federal Income Tax form, including any appropriate Schedules.
- Please send copies of letters you have telling the amount of any benefits received or a copy of any checks received.

Expenses

24. Tell us if you pay someone to take care of your child(ren) under age 12 or to take care of a dependent parent while you work.

Yes No Number of children/parents for whom you pay for care: _____
 How much do you pay? _____ weekly every two weeks twice a month monthly

25. Does anyone in your household pay court-ordered child support?

Yes No

If yes, who pays it? _____

How much per month? _____
(Please attach proof of the amount you pay.)

Resources

26. How much does the household have in cash, checking and savings accounts?

\$ _____ Name of Bank _____ \$ _____ Name of Bank _____
[Please attach a copy of most recent bank statement(s).]

27. Does anyone own the following?
(Please attach proof of anything marked Yes.)

	Yes	No	Owner's Name	Total Value
Home property				
Land, other than your home				
Vehicle(s) for transportation				
Recreational vehicle(s)				
Stocks/Bonds				
Burial plots/funds				
Life insurance				
Other (explain)				

Rights and Responsibilities

Please read carefully before signing the Application on Page 2.

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).
 - a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
 - b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about me and my family with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).
 - c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
 - d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2 above.
4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.
6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.
7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.
8. I know that I may request a hearing if I believe an error has been made in processing my application.