Programas para la Detección del Cáncer: Cada Mujer Vale
FORMULARIO DE ELEGIBILIDAD DE LA RECIPIENTE
FORMA A

Programas para la Detección del Cáncer: Cada Mujer Vale

La sección superior debe ser completada por la beneficiaria

Nombre de la beneficiaria_____ Fecha de nacimiento_____

Ingreso

Número total de miembros de la familia que viven juntos (solicitante, esposo, hijos de 20 años o menores): ☐

Ingreso mensual neto de los miembros de la familia: ☐

Seguro de salud

No tengo seguro de salud: ☐ Ninguno

Tengo este tipo de seguro de salud:
- ☐ *Medi-Cal*
- ☐ Militar
- ☐ Seguro privado
- ☐ *Medicare Part B*
- ☐ *Family PACT*
- ☐ Otro: _____

Yo certifico que la información anterior es correcta y completa:

_____ _____
Firma de la Beneficiaria Fecha de Firma

SOLO PARA USO DEL PROVEEDOR

Supporting documentation on file establishes that recipient:

☐ Meets program's age criteria for breast and cervical cancer screening and diagnostic programs.
[≥ 40 years of age for Breast Services or ≥ 25 years of age for Cervical Services]

☐ Meets program's income and insurance criteria for breast and cervical cancer screening and diagnostic programs.
[≤ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]

☐ Recipient referred for Breast and Cervical Cancer Treatment Program (Optional).

☐ Signed program's consent form.

I have determined that this woman is eligible for CDP services *.

_____ _____
Primary Care Provider Staff Certifying Signature Date Certified

To be eligible for program participation, clients must meet age, income and health insurance criteria. All three must be met for eligibility.

**Eligibility determination policies and information are located in the CDP Section of the Medi-Cal Manual*.

Complete all fields. Place original in patient chart.
ELIGIBILITY FORM A (Spanish) (1/03)