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DIVISION OF MEDICAL ASSISTANCE PROGRAMS
Oregon Health Plan

Oregon Health Authority

Breast and Cervical Cancer Treatment Program (BCCTP) Application and Referral Form

To qualify for medical benefits from the Breast and Cervical Cancer Treatment Program (BCCTP), a woman must:

- Meet the eligibility criteria of the Oregon Breast and Cervical Cancer Program;
- Have been diagnosed as needing treatment for breast or cervical cancer, or specific pre-cancerous conditions;
- Be less than 65 years old;
- Have no health insurance to pay for treatment;
- Health insurance is:
  - Individual or group health insurance;
  - Medicare;
  - Oregon Health Plan (Medicaid);
  - Armed forces insurance;
  - Family Health Insurance Assistance Program (FHIAP);
  - Oregon Medical Insurance Pool (OMIP).

If a woman qualifies, she will need to fill out more forms. If she does not fill out the required forms her medical benefits will not continue.

- The woman may be asked to fill out forms for other medical programs. This is to see if she can get benefits from a different program.
- A woman who states she is a U.S. citizen may be asked to provide verification of her citizenship.
- A woman who states she is not a citizen may be asked to provide verification of her immigration status. She may choose to state she will not provide verification of her immigration status if she does not have documentation. If this is the case, she may be eligible for emergency medical benefits.

The woman will be asked to give her Social Security Number (SSN). A woman who only wants to get emergency medical benefits is not required to give us her SSN. She can volunteer to give us her SSN. We will not share this information with INS. Emergency medical benefits will not cover breast or cervical cancer treatments.

Questions about the application can be answered at www.healthoregon.org/bcc or by calling the Breast and Cervical Cancer Program at 971-673-0581.

Assignment of rights to medical benefits

By asking for and receiving medical benefits, a person is giving to Oregon Health Authority (OHA) all rights to any medical support and to any third party payments for medical care. This allows OHA to seek payment from any third party liable to pay for the person's medical care.

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Estate claim statement

Upon a person's death, Department of Human Services and Oregon Health Authority (DHS|OHA) may take money from the person's estate *(as defined in ORS 414.104)*.The amount that can be taken is generally equal to the amount of medical benefits that a person received after age 55. If the person is permanently institutionalized *(as defined in OAR 461-135-0832)* at the time of death, medical benefits paid prior to age 55 may be recovered. The money to repay the medical benefits can be taken from the person's estate at the time of death. If the person has a surviving spouse, no claim will be made until his or her death. If there are surviving children under the age of 21, no claim will be made. If there are surviving children who are disabled, no claim will be made (ORS 115.125).

Social Security number

Social Security Numbers (SSN) are required for most people applying for medical benefits (42 USC Sec.1320b-7). An applicant does not have to give us her SSN if she is only applying for emergency medical benefits.
The SSN will be used to:

- Make sure nobody gets benefits in more than one household;
- See which benefits a person can get;
- Make changes to large numbers of cases at one time;
- Recover overpaid benefits;
- Match our records against federal and state records. For example, Unemployment Compensation, Internal Revenue Service, Medicaid and Social Security records;
- Gather workforce information and research. This helps lawmakers and agencies improve services to Oregonians.

Non-Discrimination statement

The Department of Human Services (DHS) and the Oregon Health Authority (OHA) do not discriminate against anyone. This means that DHS|OHA will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs[1], disability or sexual orientation[2].

You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons.

To file a complaint with the state, you can call the Governor's Advocacy Office at 1-800-442-5238 (TTY 711) or write to their office at:

Governor's Advocacy Office
500 Summer Street NE, E17
Salem, OR 97301
Fax: 503-378-6532
Email: DHS.info@state.or.us
"Equal opportunity is the law!"

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[1]SNAP clients are protected against political belief discrimination.

[2]Sexual orientation is protected by the State of Oregon, but not federal laws.

Rights of applicant

- To ask about OHA programs, payments and services.
- To apply for OHA programs.
- To get courteous and fair treatment without discrimination.
- To get reasonable accommodation for any disabilities per the Americans with Disabilities Act.
- To refuse to allow the release of information given to OHA unless it is required by law.
- To ask for and get a receipt for any forms given to OHA.
- To talk with a person in charge.
- To ask for a hearing on any action you disagree with. You have 45 days from the date of the notice to do this. The request must be on an Administrative Hearing Request form (DHS 443). This form is available from any OHA office. Someone at the office can help you fill it out.
- To know if you qualify for benefits within 45 days.

Responsibilities of applicant

- Give true, correct and complete information.
- Report the following changes within 10 days:
  - Changes of address;
  - Changes of other health care coverage;
  - Report if you become pregnant.
- Report changes by calling the Statewide Processing Center at 1-800-699-9075 or TTY 1-800-735-2900.
- Tell health care providers of other health care coverage before using your medical ID card.

By signing this application:

- I allow OHA to review my health care records. I allow OHA to share my health care records with OHA contractors and their providers.
- I understand the estate claim statement.
- I understand my rights and responsibilities as stated above.
- I understand the social security statement.

I affirm the information I have given in this application is true, correct and complete to the best of my knowledge.

This document can be provided upon request in alternative formats for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact Oregon Health Plan (OHP) at 1-800-699-9075 or TTY 1-800-735-2900

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PUBLIC HEALTH DIVISION
Oregon Health Plan

Oregon Health Authority

Breast and Cervical Cancer Treatment Program (BCCTP) Application and Referral Form

Please complete the following to apply for medical benefits from the BCCTP

Part 1 — Patient section

Applicant name:			Date:
Date of birth:	Social Security number:	Phone number:	Message phone:

Home address

Street:	City:	State:	ZIP code:

Mailing address: *(if different)*

Street:	City:	State:	ZIP code:

Family size: *(include yourself)* _____

Total household yearly income: *(before taxes)* _____

Are you:

A citizen of the United States? ☐ Yes ☐ No

An alien in lawful immigration status? ☐ Yes ☐ No

Do you have any type of health insurance coverage? ☐ Yes ☐ No

If yes, what type of coverage is it? *(Provide copy of insurance card, if available.)*

The following questions are to help us determine if you may qualify for another medical program.

Are you a parent or relative of a child in your home who is less than 19 years of age?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Have you applied for disability benefits?	☐ Yes	☐ No
Have you been denied disability benefits?	☐ Yes	☐ No
Are you receiving disability benefits?	☐ Yes	☐ No

I have read my rights and responsibilities on pages 2 and 3. ☐ Yes ☐ No

_____ _____

(Signature of applicant) *(Date)*

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Part 2 — Provider section

Provider name:	NPI number:	Specialty/license type:	
Clinic name:	Phone number:	Message phone:	
Street address:	City:	State:	ZIP code:

Diagnosis

Breast:	**Cervical:**
☐ Invasive breast cancer ☐ Ductal carcinoma in situ (DCIS)	☐ Persistent CIN 1 *(occurring over a period of at least 18 months)* ☐ CIN 2 or CIN 3 ☐ Invasive cervical cancer ☐ Adenocarcinoma in situ (AIS) ☐ Carcinoma in situ (CIS)

Date of diagnosis: _____

(This is the date of the procedure with which the cancer was diagnosed.)

Does patient have outstanding medical bills related to this diagnosis? ☐ Yes ☐ No

If yes, date that these bills begin: _____

Would patient have met eligibility criteria on above date? ☐ Yes ☐ No

I wish to receive the recipient's ID number expedited by fax: ☐ Yes ☐ No

Fax number: _____

Attention: _____

By signing below, I affirm the patient meets the eligibility guidelines on page one of this application, the information listed in this section is true and complete and I am qualified to make this diagnosis.

_____ _____

(Signature of provider) *(Date)*

Fax completed form to: 503-373-7493