# Illinois Breast and Cervical Cancer Program
## Eligibility Determination Form

| ☐ **New Client**<br>Registration Date: _______________ | ☐ **Established Client**<br>Annual Verification Date: ____________ | Cornerstone # (Office Use Only):<br>____________________________ |
|---|---|---|

Name: _______________________________________ Day Phone: ____________________________________

Maiden Name: _______________________________ Night Phone: ___________________________________

Address: _____________________________________ Age: ________ Birth Date: _______/______/__________

City: _________________________________________ Social Security #: __________-________-____________

State: ________ Zip Code: ______________________ Alternate Contact: ______________________________

County: _______________________________________ Day Phone: ____________________________________

**Income Eligibility:**
If single - total income before taxes or if married - total combined income before taxes: $___________ per month/year (circle one)

Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: ________

Office Use Only: Income status for number in household:

At or below 250% of poverty federal level: ☐ Yes ☐ No Above 250% of federal poverty level: ☐ Yes ☐ No

**Medical/Insurance Coverage:** ***Check all that apply.***

☐ Medicare Part B – Not eligible for IBCCP

☐ Medicaid ID number__________________________

☐ I DO NOT have insurance

☐ I have Insurance - Name of Carrier: ______________________________________

☐ Are you covered under a parent or spouse insurance? ☐ No ☐ Yes

Does insurance pay for: Pap tests? ☐ No ☐ Yes Mammograms? ☐ No ☐ Yes

**Please provide a copy of the front and back of your insurance card.**

**Marital Status/Relationship:**
☐ Never Married (01)
☐ Married (02)
☐ Widowed (03)
☐ Divorced (04)
☐ Separated (05)
☐ Unknown (09)
☐ Other_______________

**Years of Education Completed:**
☐ _________ (EO # of years)
☐ None (E000)
☐ Unknown (E099)

**Employment Status:**
☐ Employed full-time (35+ hours weekly) (EFT)
☐ Employed part-time (EPT)
☐ Not in the labor force (NLF)
☐ Other seasonal worker (OSW)
☐ Seasonal/Migrant Farm Worker (SMF)
☐ Unemployed (UNE)
☐ Unknown (UNK)

**Are you of Hispanic origin?** ☐Yes (01) ☐ No (00)

**What races do you consider yourself? Mark ALL that apply.**
☐ White
☐ Black or African American
☐ Asian
☐ Chinese ☐ Indian ☐ Japanese ☐ Korean ☐ Filipino
☐ Vietnamese ☐ Other
☐ Native Hawaiian/Other Pacific Islanders
☐ American Indian/Alaskan Native
☐ Unknown

**How did you hear about this program?**
☐ Poster (PO)
☐ Flier (FL)
☐ Brochure (BR)
☐ Case Management Outreach (C)
☐ Community Event (CE)
☐ State Promotional Campaign (ST)
☐ Physician or Health Care Provider (P)
Who: ______________ Phone #: _________
☐ Newspaper (ME)
☐ Radio (ME)
☐ Television (ME)
☐ Other (OTH), Specify: __________________

**What is the best time to schedule your appointments?** (Please mark your choices.)

**Day of the week**: Monday Tuesday Wednesday Thursday Friday

**Time of day:** Early morning Mid morning Early afternoon Late afternoon

**Preferred Healthcare Provider:** ___________________________________________________________

I understand that if I have given false information or intentionally failed to disclose information for this application, I may be subject to criminal prosecution, civil action or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.

**Applicant's Signature** _____________________________________________ **Date** __________________