Illinois Breast and Cervical Cancer Program
Eligibility Determination Form

Shaded area is for IBCCP office use only

☐ **New Client** Registration Date: _____	☐ **Established Client** Annual Date: _____	☐ **Navigation Only** Date: _____	**Cornerstone #** _____

Name: _____

Previous Last Name: _____

Age: _____ Birth Date: _____/_____/_____

Address: _____

City: _____ State: _____

Zip Code: _____ County: _____

Home Phone: _____

Cell Phone: _____

Day Phone: _____

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

If yes, Insurer Name: _____

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

Do you have a deductible that must be met before diagnostic procedures are covered? ☐ No ☐ Yes

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

Employment Status:
☐ Employed full-time (35+ hours weekly) (EFT)
☐ Employed part-time (EPT)
☐ Not in the labor force (NLF)
☐ Seasonal/Migrant Farm Worker (SMF)
☐ Self-employed (SE)
☐ Temporary Worker (TW)
☐ Unemployed (UNE)

Marital Status:
☐ Never Married (01)
☐ Married (02)
☐ Other: _____

Years of Education Completed:
☐ _____ (EO # of years)
☐ Unknown (E099)

Income determination:

(circle one)
Total income before taxes (if married - total combined income before taxes): $_____ per month/year

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 federal poverty level: ☐ Above 250% of federal poverty level: ☐

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

Preferred language for delivery of service:
☐ English (E)
☐ Spanish (S)
☐ Other (O):_____

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

How did you hear about this program?
☐ Poster (PO) ☐ Newspaper (ME)
☐ Flier (FL) ☐ Radio (ME)
☐ Brochure (BR) ☐ Television (ME)
☐ Community Navigator (C) ☐ Website (Agency/State) (WB)
☐ Community Event (CE)
☐ Physician or Health Care Provider (P)
Who: _____ Phone #: _____
☐ Other (OTH), Specify: _____

Barriers:
☐ None ☐ Transportation ☐ Child/family Care ☐ Work schedule
☐ Understanding medical needs ☐ Special needs ☐ Financial
☐ Need Interpreter ☐ Travel Distance ☐ Making appointments
☐ Other: _____

Comments:
_____
_____

What is the best time to schedule your appointments?
(Please mark your choices.) **Preferred Healthcare Provider:** _____

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

Time of day: ☐ Early morning ☐ Mid-morning ☐ Early afternoon ☐ Late afternoon

I certify that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature _____ **Date** _____