



**Medicaid Application for Participants in the  
Breast and Cervical Cancer Screening Program Only**

This application is for individuals who were screened and approved by a Breast and Cervical Cancer Screening Program (BCCSP) provider and are receiving active treatment for their diagnosis. The Centers for Disease Control and Prevention's Certificate of Diagnosis for Medicaid coverage must be attached.

If you need assistance with this application, contact your WVBCSP Screening Provider or call 1-800-642-8589.

**Contact Information:**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
                    Last                      First                      MI  
Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
                                    Box/Route/Street  
Address: \_\_\_\_\_ Age: \_\_\_\_\_  
                                    City/Town, State, Zip  
Phone: \_\_\_\_\_ Emergency  
                                    Contact: \_\_\_\_\_

Do you or anyone in your household need an accommodation because of a condition that would prevent you from completing this application: ☐ Yes or ☐ No If yes, please explain: \_\_\_\_\_

**Additional Information:**

Are you covered by any type of medical insurance? ☐ Yes or ☐ No

If yes, what type of insurance? \_\_\_\_\_

1. I certify that I have read and understand the questions. I certify that the information that I have given is true and correct.
2. I give permission to any financial institution, government agency or department doctor, hospital, business, or person to give any information to an employee of the department which would have to do with my receiving medical benefits.
3. I know that no person may be denied Medicaid benefits on the grounds of race, color, sex, disability, religion, national origin, or political belief.
4. I understand, if I give incorrect or false information or if I fail to report changes, then I may be required to pay any benefits that I receive. I may be prosecuted for fraud, and I understand that any information given is subject to verification by an authorized representative of the department.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
                                    (Applicant or Authorized Representative)