West Virginia Department of Health

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 WVBCCSP 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)