

NEW TO BCCHP PROGRAM? Yes No

Please Print

FEMALE

MALE

Authorization # _____

NAME Last First MI			BCCHP PRIME CONTRACTOR WENT		DATE (mm/dd/yyyy)
Previous Name			Wenatchee Valley Medical Center		CHART NUMBER
DATE OF BIRTH (mm/dd/yyyy)			CLINICAL SCREENING SITE:		
SOCIAL SECURITY NUMBER			APPOINTMENT DATE & TIME:		

ADDRESS _____

CITY	STATE	ZIP	COUNTY OF RESIDENCE
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HOME PHONE NUMBER () ()	WORK PHONE NUMBER () ()	ALTERNATE CONTACT INFORMATION:	BEST TIME TO CALL: <input type="checkbox"/> AM <input type="checkbox"/> PM
			MAY WE LEAVE A MESSAGE?

PROGRAM ELIGIBILITY (must be assessed annually)
 Household Income Before Taxes:
 \$ _____ Annual Monthly Number of people who live on this income _____

Insurance/Medical Coverage Yes No If Yes, Name of insurance company or list medical coverage: _____
 Policy/Identification Number _____ Deductible: _____

Breast symptoms? Yes No Colorectal: symptoms Yes No; Family/self history of Colorectal cancer? Yes No

Birth Country? USA Other (specify) _____

Are you Latino or Hispanic? (For example, Mexican-American, Puerto Rican, Cuban) Yes No

Primary Language? (select only one) English Vietnamese Korean Spanish
 Cambodian Russian Chinese Other (specify) _____

What race(s) are you? (Mark one or more race(s) to indicate what you consider yourself to be.)
 White/Caucasian Native Hawaiian or Other Pacific Islander (specify) Black or African-American
 Asian American Indian or Alaskan Native (specify Tribe/Nation) _____ Unknown

What is the highest grade of school you have completed? (number of school years)

If you are new to BCCHP, how did you learn about this program? (select only one)

<input type="checkbox"/> Self	<input type="checkbox"/> Employer	<input type="checkbox"/> TV	<input type="checkbox"/> Breast Cancer Prevention Fund
<input type="checkbox"/> Friend or Relative	<input type="checkbox"/> Handout	<input type="checkbox"/> Radio	<input type="checkbox"/> BCCHP Internet Website
<input type="checkbox"/> Community Group	<input type="checkbox"/> Religious Organization	<input type="checkbox"/> Poster	<input type="checkbox"/> Ask Me Campaign
<input type="checkbox"/> Clinic	<input type="checkbox"/> Mailing	<input type="checkbox"/> YWCA	
<input type="checkbox"/> Outreach Worker	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Other (specify) _____	

BCCHP Client Consent Form has been signed.

PLEASE FAX TO BCCHP PRIME CONTRACTOR: (509) 667-7352