



**Cancer Detection Programs: Every Woman Counts**  
**RECIPIENT ELIGIBILITY FORM (continued)**

BCCTP Enrollment Date:

The purpose of this enrollment is to only refer the recipient to BCCTP Breast Cancer Treatment:

Breast Final Diagnosis Date:

Breast Final Diagnosis (check one):

- |  |  |
|--|--|
| <input type="checkbox"/> Atypical Ductal Hyperplasia (ADH)         | <input type="checkbox"/> Papillary Carcinoma                   |
| <input type="checkbox"/> Lobular Neoplasia                         | <input type="checkbox"/> Tubular Carcinoma                     |
| <input type="checkbox"/> Lobular Carcinoma in Situ (LCIS)          | <input type="checkbox"/> Paget's Carcinoma of the Breast       |
| <input type="checkbox"/> Atypical Lobular Hyperplasia (ALH)        | <input type="checkbox"/> Malignant Phyllodes Tumor             |
| <input type="checkbox"/> Ductal Carcinoma In Situ, Comedo Type     | <input type="checkbox"/> Metastatic Cancer with Breast Primary |
| <input type="checkbox"/> Ductal Carcinoma In Situ, Non-Comedo Type | <input type="checkbox"/> Carcinosarcoma                        |
| <input type="checkbox"/> Infiltrating Ductal Carcinoma             | <input type="checkbox"/> Primary Non-Hodgkins Lymphoma         |
| <input type="checkbox"/> Infiltrating Lobular Carcinoma            | <input type="checkbox"/> Inflammatory Breast Carcinoma         |
| <input type="checkbox"/> Medullary Carcinoma                       | <input type="checkbox"/> Adenoid Cystic Carcinoma              |
| <input type="checkbox"/> Mucinous or Colloid Carcinoma             | <input type="checkbox"/> Breast Malignancy NOS                 |

The purpose of this enrollment is to only refer the recipient to BCCTP Cervical Cancer Treatment:

Cervical Final Diagnosis Date:

Cervical Final Diagnosis (check one):

- |   |  |
|---|--|
| <input type="checkbox"/> High Grade Squamous Cell Intraepithelial Lesion (HSIL)       | <input type="checkbox"/> Carcinoid Carcinoma                                     |
| <input type="checkbox"/> Adenoid Cystic Carcinoma                                     | <input type="checkbox"/> Small Cell Carcinoma or Neuroendocrine Carcinoma        |
| <input type="checkbox"/> Cervical Intraepithelial Neoplasia II (CIN II)               | <input type="checkbox"/> Metastatic Cancer with Cervical or Endocervical Primary |
| <input type="checkbox"/> Cervical Intraepithelial Neoplasia III (CIN III)             | <input type="checkbox"/> Cervical Sarcoma  |
| <input type="checkbox"/> Atypical Glandular Cells of Undetermined Significance (AGUS) | <input type="checkbox"/> Cervical Melanoma                                       |
| <input type="checkbox"/> Adenocarcinoma In Situ (ACIS)                                | <input type="checkbox"/> Mesonephric Carcinoma                                   |
| <input type="checkbox"/> Adenocarcinoma   | <input type="checkbox"/> Moderate Dysplasia                                      |
| <input type="checkbox"/> Squamous Cell Carcinoma                                      | <input type="checkbox"/> Severe Dysplasia  |
| <input type="checkbox"/> Adenoma Malignum   | <input type="checkbox"/> Carcinoma In Situ                                       |
| <input type="checkbox"/> Adenosquamous Carcinoma                                      | <input type="checkbox"/> Malignant Mixed Mullerian Tumor                         |
| <input type="checkbox"/> Glassy Cell Carcinoma  | <input type="checkbox"/> Cervical Malignancy NOS                                 |

**PROVIDER USE ONLY Eligibility Checklist**

Supporting documentation on file establishes that recipient:

21.  Meets CDP: EWC program age, income and insurance criteria.  
     [ ≥ 50 years of age for Breast Services or ≥ 25 years of age for Cervical Services]  
     [ ≤ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]
22.  Signed CDP: EWC consent form

I have determined that this woman is eligible for BCCTP enrollment.\*

\_\_\_\_\_  
 Primary Care Provider Staff Certifying Signature

\_\_\_\_\_  
 Date Certified

\*Eligibility determination policies and information are located in the Cancer Detection Programs' Section of the Medi-Cal Manual.