Maine CDC Breast and Cervical Health Program (MBCHP)
INITIAL ENROLLMENT APPLICATION

NOTE: ***Please PRINT your answers and respond to all questions.***

BACKDATE SECTION
Date of Backdate:_____
Service Performed:_____
Facility/Provider:

Name (First, MI, Last): _____

Home Address: _____
City: _____ State: _____ Zip: _____

Mailing Address (if different): _____
City: _____ State: _____ Zip: _____

Cell Phone: (___)_____

Home Phone: (___)_____

Date of Birth: _____

Social Security: _____

Email: _____

Ethnicity:
Are you Spanish, Hispanic or Latino? ❑Yes ❑ No

Race: *Select more than one if applicable:*
❑White
❑Black/African American
❑Asian
❑American Indian/Alaskan Native
❑Native Hawaiian/Pacific Islander
❑Other, Specify:_____

Preferred Language:_____Would you like an interpreter?_____

Income:

$_____ Current Annual Household Income
(Examples include employment wages, unemployment, alimony, worker's compensation, Social Security, etc.)

_____ **Number of people (including yourself) in household who are supported by this income**
(Include applicant, spouse, and dependent children under 21)

Health Information Questions BEFORE you applied for MBCHP Enrollment:

Have you ever had a **Mammogram**? ❑No ❑Yes **If YES**, approximate month/year last done: _____

Have you ever had a **Pap test**? ❑No ❑Yes **If YES,** approximate month/year last done: _____

Have you had a **Hysterectomy**? ❑No ❑Yes **If YES,** list approximate Month and Year: _____
Was hysterectomy for cervical cancer? ❑ Yes ❑ No ❑ Not sure
Do you still have part of your cervix? ❑ Yes ❑ No ❑ Not sure

Health Care Coverage Questions:

Do you have Medicare Part A? ❑ No ❑Yes
Do you have Medicare Part B? ❑No ❑Yes
Do you have MaineCare (Medicaid)? ❑ No ❑Yes
Do you have any other health insurance? ❑ No ❑Yes – **If Yes, please answer Questions below:**

Name of Insurance Company: _____ Phone: _____
Policy #: _____ Group #:_____
Name of Policy Holder: _____
Policy Holder Social Security #: _____ Policy Holder Date of Birth: _____
Is Insurance through your (or spouse/partner's) employer? ❑No ❑Yes
If YES, Employer Name: _____

MBCHP Provider Location:
*Medical provider, not mammgoram facility

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