The Louisiana Breast & Cervical Health Program (LBCHP)

What is the LBCHP?

The LBCHP is a breast and cervical cancer screening program. It provides no-cost screenings for Louisiana women between the ages of 21 and 64 whose household income is at or below 200 percent of the Federal Poverty Level. Some breast and cervical cancer screening services include clinical breast exam, mammogram, pelvic exam, Pap test, diagnostic tests and health education.

Does the LBCHP provide cancer treatment?

Not directly. The LBCHP does not provide or pay for treatment services. The program only provides screening services. However, LBCHP providers (lbchp.org/screening-locations) can enroll all uninsured women diagnosed with cancer in Medicaid under the Breast and Cervical Cancer (BCC) Program, if they qualify. The BCC application is a two-page Medicaid application with a fast track approval process. Women diagnosed with breast or cervical cancer through LBCHP may qualify for Medicaid through this application. This includes women already enrolled in the Take Charge Plus family planning program.

Take Charge Plus recipients between 50 and 64 years of age in need of a mammogram should be referred to an LBCHP screening location.

I'm a clinician and one of my TCP recipient patients was diagnosed with cervical cancer. How can I get her on Medicaid so she can start treatment?

1. Have the patient complete the BCC application (item #2 can be left blank).
2. Verify the patient's contact information listed on the application.
3. Fax the application along with the final pathology report to 504-568-5838.

Call 504-568-5878 or 1-888-599-1073 with any questions.

LOUISIANA BREAST & CERVICAL HEALTH PROGRAM

Information Line
1-888-599-1073

Website
lbchp.org

Address
2020 Gravier St., 3rd Floor
New Orleans, LA 70112

Program Manager
Nannozi Ssenkoloto, MPH

BHSF Form 1-BCC
Rev. 8/15

Medicaid
Breast and Cervical Cancer Program Application

Louisiana's Breast and Cervical Cancer Program is only for **women** who have been **screened** under the Center for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast and/or cervical cancer, including precancerous conditions. The program provides full Medicaid benefits, like prescriptions and hospital and doctor visits.

To apply:

1. **Get** a CDC screening by calling 1-888-599-1073.
2. **Fill out** this form and **sign** it.
3. **Mail** or **fax** the form and proof of screening to the Medicaid Application Office as soon as possible.
4. **If you need help** with this form, call us toll free at 1-888-342-6207 (TTY: 1-800-220-5404).

1. Give us the following information about yourself (person who is applying).

First name, Middle name, Last name, & Suffix _____

Social Security Number (SSN) _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____

Mailing Address _____ City _____ State _____ Zip Code _____

Parish _____

Phone Number _____ Other Phone Number _____

What is your preferred spoken or written language (if not English)? _____

If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Race (OPTIONAL—check all that apply.)

☐ Black or African American	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ White	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, were you born in the U.S. or a U.S. territory? ☐ Yes ☐ No **If no,** fill in your information below (if it applies to you).
a. Alien number _____ b. Certificate type _____ c. Certificate number _____
If no, do you have eligible immigration status? ☐ Yes ☐ No **If yes,** fill in your information below (if it applies to you).
a. Document type _____ b. Document expiration date (mm/dd/yyyy) _____
c. Alien, I-94, or SEVIS ID number _____ d. Card or Passport number _____
e. Have you lived in the U.S. since 1996? ☐ Yes ☐ No f. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

2. Do you have proof of the Early Detection Program screening and diagnosis? ☐ Yes ☐ No If **Yes**, please give us proof of the screening and findings. If **No**, please contact Louisiana's Early Detection Program at 1-888-599-1073 to get the proof. **(You do not have to wait for the proof, apply now.) A screening is required to be eligible for Medicaid coverage under this program.**

3. Do you want help paying for medical bills (paid or unpaid) for medical care received in the past 3 months? ☐ Yes ☐ No

4. Do you have private health insurance? ☐ Yes ☐ No If **Yes**, give the following information.
Insurance Company Name _____ Address _____
Phone Number _____ Group/Policy Number _____
Is treatment for breast/cervical cancer covered? ☐ Yes ☐ No

5. Will you be included on someone's federal tax return **NEXT YEAR**? ☐ Yes ☐ No
a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

6. Are you pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

7. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

8. Were you in foster care at age 18 or older? ☐ Yes ☐ No
   a. **If yes,** in which state? _____ b. Were you on Medicaid? ☐ Yes ☐ No c. How old were you when you left foster care? _____

9. Do you and/or your husband get money from anywhere? ☐ Yes ☐ No
   Job 1: Employer name, address, and phone number _____
   Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
   How much? _____ Average hours worked each WEEK_____
   Job 2: Employer name, address, and phone number _____
   Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
   How Much? _____Average hours worked each WEEK_____
   Self-employment: Type of work _____ How much net profit will you get this month? _____
   Other sources (Social Security, Pensions, Unemployment, etc.)**:**
   Type: _____ How much? _____ How Often? _____
   Type: _____ How much? _____ How Often? _____

Read and sign this application

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.

- I know that I must tell Medicaid if anything changes (and is different than) what I wrote on this application. I can visit **www.medicaid.dhh.la.gov** or call **1-888-342-6207** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household. changes: 1) if anyone getting Medicaid moves out of state; 2) changes in where we live or get our mail; 3) changes in health insurance and premiums; 4) changes in income; 5) changes in the things we own if anyone who gets Medicaid is disabled or over age 64; and 6) if a pregnancy ends.

- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**, calling the US DHHS Regional Office for Civil Rights at **1-800-368-1019**, or writing to Louisiana DHH at **PO Box 4818, Baton Rouge, Louisiana 70821**.

We need the information you provide on this application to check your eligibility for help paying for health coverage if you apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.
☐ Yes, renew my eligibility automatically for the next (choose one): ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
☐ No, don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid
I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

My right to appeal
If I think the Health Insurance Marketplace or Louisiana Medicaid has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Medicaid at **1-888-342-6207**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

_____ _____
Signature of Applicant or Authorized Representative **Date**

Please mail this signed form as soon as possible to the Medicaid Application Office, PO Box 91278, Baton Rouge, LA 70821-9893. You can also fax it to 1-877-523-2987. If you need additional help, visit our website at www.Medicaid.DHH.Louisiana.gov or call us at 1-888-342-6207 (TTY: 1-800-220-5404).