

Every Woman Counts (EWC) Program Application Form

Applicant Identification

- **Submission Date:** 05/14/2025
 - **Full Name:** Laura Martinez
 - **Date of Birth:** 03/10/1980 (Age: 45)
 - **Address:** 1023 Cedar Street, Fresno, CA 93721
 - **Phone Number:** (559) 555-1122
 - **Email:** laura.martinez@example.com
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Insurance & Income Information

- **California Resident:** Yes ☒
 - **Health Insurance Status:**
 - No health insurance ☒
 - Limited insurance with unaffordable copay/deductible ☐
 - Eligible for Medi-Cal ☐
 - **Monthly Household Income:** \$2,400
 - **Household Size:** 2
 - **Income as % of FPL:** 165% ☒ (Up to 200% allowed)
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Screening Services Requested

- Clinical Breast Exam & Mammogram (Age 40+): Yes ☒
 - Pap Test (Age 21+): Yes ☒
 - HPV Test (with Pap): No ☐ Yes ☐
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Program Referral Source

- Referred by: FQHC Family Clinic
 - Referral Method:
 - Automated referral line (800-511-2300) ☐
 - Online provider locator ☐
 - In-person/mailing of EWC brochure ☒
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Declarations & Consent

I certify that the information provided is true and accurate. I understand that these services are free of charge under the Every Woman Counts Program and that I may be referred into the Breast & Cervical Cancer Treatment Program if additional treatment is needed.

- Applicant Signature: _____ Date: // ____
 - Staff Signature: _____ Date: // ____
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Provider Notes (Office Use Only)

- Eligibility Verified By: _____ Date: // ____
- Income Documentation: Verified ☐ Pending ☐
- Appointment Scheduled: ☐ Date: // ____ Time: ____

• **BCCTP Referral:** ☐ Yes ☐ No

• **Additional Remarks:** _____