Every Woman Counts (EWC) Program Application Form

Applicant Identification

- **Submission Date:** 05/14/2025
- **Full Name:** Angela Kim
- **Date of Birth:** 11/05/1972 (Age 52)
- **Address:** 456 Oak Avenue, San Diego, CA 92103
- **Phone Number:** (619) 555-3344
- **Email:** angela.kim@example.com

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:** $3,800
- **Household Size:** 1
- **Income as % of FPL:** 210% ⬜ (over limit, but copay qualifies)

Screening Services Requested

- **Clinical Breast Exam & Mammogram (Age 40+):** Yes ☑️
- **Pap Test (Age 21+):** Yes ☑️
- **HPV Test (with Pap):** No ⬜ Yes ⬜

Program Referral Source

- Referred by: Private OB/GYN Office
- Referral Method:
    - Automated referral line (800-511-2300) ☑️
    - Online provider locator ⬜
    - In-person/mailing of EWC brochure ⬜

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: //____**

Provider Notes (Office Use Only)

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

- **BCCTP Referral:** ⬜ Yes ⬜ No
- **Additional Remarks: _____**