Every Woman Counts (EWC) Program Application Form

Applicant Identification

- **Submission Date:** 05/14/2025
- **Full Name:** Emily Jackson
- **Date of Birth:** 02/28/1985 (Age 40)
- **Address:** 789 Pine Road, Sacramento, CA 95816
- **Phone Number:** (916) 555-6677
- **Email:** emily.jackson@example.com

Insurance & Income Information

- **California Resident:** Yes ☑️
- **Health Insurance Status:**
    - No health insurance ⬜
    - Limited insurance with unaffordable copay/deductible ⬜
    - Eligible for Medi-Cal ⬜
    - Covered by employer-sponsored plan ☑️
- **Monthly Household Income:** $4,500
- **Household Size:** 3
- **Income as % of FPL:** 195% ☑️

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: _____**