State of California - Health and Human Services

Department of Health Care Services

COUNTY REFERRAL TO THE BREAST & CERVICAL CANCER TREATMENT PROGRAM (BCCTP)

INSTRUCTIONS

Per ACWDL 22-02, BCCTP requires that a county complete this form with all known information at the time of completion, and submit the document via email (BCCTP@dhcs.ca.gov) or fax (916-440-5693). If there are comments or other information necessary for this referral, please attach a separate sheet and submit with this form. Contact a BCCTP Eligibility Specialist at 1-800-824-0088 for any questions.

Applicant / Beneficiary Information

Preferred Spoken Language: SELECT ONE _____ OTHER: _____

Applicant / Beneficiary Name

_____ _____ ____
LAST FIRST MI

Phone Contact Information ☐ *Check if BCCTP can leave a message*

Daytime (_____)_____ Message: (_____)_____

Authorized Representative: ☐ *Yes* ☐ *No*

_____ _____ (_____) _____
Last Name First Name Phone

Case Information

Case number: CIN:

Monthly Gross Household Income (before taxes, deductions or expenses): $ _____

Household Composition (Include applicant within "Total Household Composition" figure):

Spouse: _____ Children (under age 21): _____ Total Household Composition: 1

This referral is for a: ☐ New Applicant ☐ Existing Beneficiary

County Eligibility Worker (EW) Information

County Name: SELECT ONE EW Name_____

EW Desk Phone #: (_____) _____ Ext _____ EW Fax #: (_____) _____

Date that Applicant/Beneficiary Requested BCCTP Referral: _____