Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

FINANCIAL ELIGIBILITY

Client Name:_____ **Date of Birth:**_____ **ID#**_____

1. Do you have Medicaid? ☐ YES ☐ NO **OR** Do you have Medicare? ☐ YES ☐ NO
2. Do you have any form of health insurance? ☐ YES ☐ NO Name of insurance _____
3. **Number of people in your Household.** _____ (include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes): $**_____Month **OR $**_____Year

Family Size	2022 DOH Scale Monthly Income	2022 DOH Scale Yearly Income
1	$2,264.91	$27,179.00
2	$3,051.58	$36,619.00
3	$3,838.25	$46,059.00
4	$4,624.91	$55,499.00
5	$5,411.58	$64,939.00
6	$6,198.25	$74,379.00
7	$6,984.91	$83,819.00
8	$7,771.58	$93,259.00
9	$8,558.25	$102,699.00
10	$9,344.91	$112,139.00

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:

If I obtain health insurance coverage, while under the FBCCEDP, it is my responsibility to notify the REGIONAL FBCCEDP office as soon as possible.

Signature_____

Date _____

If you have any questions, please call the regional coordinator at_____between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.