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	2020 DOH Scale Monthly Income	2020 DOH Scale Yearly Income
1	$2,126.58	$25,519.00
2	$2,873.25	$34,479.00
3	$3,619.92	$43,439.00
4	$4,366.58	$52,399.00
5	$5,113.25	$61,359.00
6	$5,859.92	$70,319.00
7	$6,606.58	$79,279.00
8	$7,353.25	$88,239.00
9	$8,099.92	$97,199.00
10	$8,846.58	$106,159.00

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 **(407)665-3244**________________________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.