

Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

FINANCIAL ELIGIBILITY

Cli	ent Name: ID# Date of Birth: ID# ID#
1.	Do you have <u>Medicaid</u> ? YES NO <u>OR</u> Do you have <u>Medicare</u> ? YES NO
2.	Do you have any form of <u>health insurance</u> ? 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	2021 DOH Scale Monthly Income	2021 DOH Scale Yearly Income
1	\$2,146.58	\$25,759.00
2	\$2,903.25	\$34,839.00
3	\$3,659.91	\$43,919.00
4	\$4,416.58	\$52,999.00
5	\$5,173.25	\$62,079.00
6	\$5,929.91	\$71,159.00
7	\$6,686.58	\$80,239.00
8	\$7,443.25	\$89,319.00
9	\$8,199.91	\$98,399.00
10	\$8,956.58	\$107,479.00

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.