COLORADO
Department of Health Care Policy & Financing

PRESUMPTIVE ELIGIBILITY FORM
COLORADO MEDICAID BREAST AND CERVICAL CANCER PROGRAM

Name _____ _____ _____ Social Security # _____
Last First Middle

Mailing Address _____ _____ Home Phone _____
Box or Route Number and Street Apt

_____ Work Phone _____
City/Town State Zip (If you can receive calls at work)

Date of Birth _____ Cell/Other _____

Do you have medical insurance? Yes ☐ No ☐ If yes, what type? Medical ☐ Hospital ☐ Cancer Other _____

Policy Number _____ Company Name _____ Phone _____

*Do you have children under the age of 19? Yes ☐ No ☐

*What is your monthly gross income? _____

*Do you have a diagnosed disability? Yes ☐ No ☐

*These questions are being asked to determine your eligibility for other Medicaid programs.

1. I certify that all statements on this form have been read by me or read to me and I understand the questions. I certify that all the information I have given is true and correct.
2. I give my permission for any financial institution, government agency or department, doctor, hospital, business concern, or person to give any information to an employee of the Department which would have to do with my receiving benefits.
3. I know that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
4. I understand that if I give incorrect or false information or if I fail to report changes, then I may be required to repay any benefits I receive. I understand that any information given is subject to verification by an authorized representative of the Department.
5. I understand that by accepting medical assistance under BCCP, I agree to give back to the State any and all money that is received from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has made or will make payment.
6. I understand that the Medicaid application must be completed and submitted within 30 days of the date on this form to receive benefits under this program.

_____ _____
Signature of Applicant Date

_____ _____
Witness, if signed by mark Signature of person helping to complete the form

Medicaid State ID Issued _____

Date Help Desk Was Called _____

WWC Site Number _____

WWC Site Phone _____

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