Thank you for your interest in the program. If you have any questions or need help filling out this application, contact the program at 1-800-264-1296.

Colorectal and Breast & Cervical Cancer Screening Programs Enrollment Form

I am enrolling in: ☐ Breast and Cervical (WBCCEDP) and/or ☐ Colorectal (WCCSP) or ☐ Both

Applicant Information

First Name, MI, Last Name:		Date of Birth: Age:
Social Security Number (if applicable):		Please Circle: MALE FEMALE
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address (Street or PO Box): Apt. #:		County:
City:	State:	ZIP Code:
Alternate Contact/Relationship:		Phone:

What race/ethnicity are you? (circle all that apply)

American Indian	White	Asian	Unknown
Black/African American	Pacific Islander/Hawaiian	Hispanic/Latino	Other:

What is your primary language?

Have you been a Wyoming resident for at least 1 (one) year? **YES** **NO**

Do you currently smoke/use tobacco products? **YES** **NO**

How Did You Hear About the Program? (Circle All that Apply)

Health Care Provider	Patient Navigator	Mailing/Flyer
Indian Health Services	Wyoming Cancer Resource Services	Website
Public Health Nurse	Family/Friend	Television/Radio
Free Clinic	Health Fair/ Community Event	Newspaper/Magazine
Other:		

Tell Us About Your Medical Provider (If Applicable)

Name of Healthcare Provider and Clinic:		
Phone:	City:	State:

The following sections help us determine your eligibility for the program.

Tell Us About Your Insurance Status

Do you currently have medical insurance? **YES** **NO**

Do you have Medicaid? **YES** **NO**

Do you have Medicare? **Part A only** **or** **Part A&B** **NO**

What is your household's monthly gross income (before taxes)?
Be sure to include all income from all members in the household.

How many people live in your household?

Please continue application on next page.

Complete If You Are Applying for a Free Colonoscopy (Men and Women)

Have you ever been diagnosed with any of these conditions? Circle all that apply:

Colon or rectal cancer	Crohn's Disease	Familial Adenomatous Polyposis
Ulcerative Colitis	Inflammatory Bowel Disease	Hereditary Non Polyposis Colorectal Cancer

Have you ever had the following screenings?

Fecal Occult Blood Test (FOBT) Fit Test	NO	YES	Date:	FIT Result:	Positive	Negative	Don't know
Colonoscopy	NO	YES	Date:	Were polyps removed?			

Have any family members (parents, siblings, children) been told they have colon or rectal cancer or colon polyps?	YES NO How many?
How many of those family members were under the age of 60 when diagnosed with colon cancer?	

Complete If You Are Applying for a Free Mammogram and/or Pap Test (Women Only)

Have you had a hysterectomy?	YES	NO	If yes, was your cervix removed?	YES	NO
Have you had breast cancer?	YES	NO	If yes, when?		
When was your last Pap test?		Date:	Was it abnormal?	YES	NO
When was your last mammogram?		Date:	Was it abnormal?	YES	NO
When was your last clinical breast exam?		Date:	Was it abnormal?	YES	NO

If you have had an abnormal exam in the last three months, a copy of the report is required.

Authorization

By signing below, I am certifying that the information I have provided is accurate to the best of my knowledge. I understand that if I am accepted into this program, and I have knowingly provided false information, I may be required to repay any benefits I have received. By agreeing to take part in this program, I give my permission to healthcare providers, billing agencies, Wyoming Department of Health, the Centers for Disease Control and Prevention, and others involved in my care to share medical information obtained. The Wyoming Department of Health (WDH) uses information in accordance with State and Federal law and the WDH Notice of Privacy Practices (NoPP). The WDH NoPP can be found on the Wyoming Department of Health's website at www.health.wyo.gov or a copy can be requested by calling 1-800-264-1296.

Patient Signature: Date:

Print Name:

Please submit the application by email, mail or fax:

Mailing Address: **Wyoming Integrated Cancer Services**
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002

Fax: 307-777-3765

Email: wdh.cancerservices@wyo.gov

If you have any questions or need help filling out this application, contact the program at 1-800-264-1296 or visit our website: www.health.wyo.gov/publichealth/prevention/cancer.

Office use only:	Approved	Denied	Date:
Staff Notes:			State ID:
			Ref Loc: