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Oregon Department of Human Services

Oregon Health Authority

Breast and Cervical Cancer Treatment Program (BCCTP) Application and Referral Form

To qualify for medical benefits from the Breast and Cervical Cancer Treatment Program (BCCTP), an individual must:

- Meet the eligibility criteria of the Oregon Breast and Cervical Cancer Program;
- Have been diagnosed as needing treatment for breast or cervical cancer, or specific pre-cancerous conditions;
- Be less than 65 years old;
- Have no health insurance to pay for treatment; health insurance is:
  - Individual or group health insurance;
  - Medicare;
  - Oregon Health Plan (Medicaid);
  - Armed forces insurance;
  - Family Health Insurance Assistance Program (FHIAP);
  - Oregon Medical Insurance Pool (OMIP).

  Note: If other health insurance does not cover *treatment* of the breast or cervical cancer, the individual may still be eligible for BCCTP.

If an individual qualifies, they will need to complete a full medical application. If they do not return this information to us their medical benefits will not continue.

- The individual may be asked to fill out forms for other medical programs. This is to see if they can get benefits from a different program.
- An individual who states they are a U.S. citizen may be asked to provide verification of citizenship.
- An individual who states they are not a citizen may be asked to provide verification of immigration status. They may choose to state they will not provide verification of immigration status if they do not have documentation. If this is the case, they may be eligible for Healthier Oregon benefits. Healthier Oregon benefits are the same as full OHP and include cancer treatment. To learn more, visit Oregon.gov/HealthierOregon.

The individual will be asked to give their Social Security Number (SSN). An SSN is required for everyone who is applying for health benefits and who has one. You can still apply for health benefits even if you don't have an SSN. If you need help getting an SSN, we may be able to help. You can call us at 1-800-699-9075. You can also visit www.socialsecurity.gov, or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Questions about the application can be answered at https://www.oregon.gov/oha/HSD/OHP/Pages/BCCTP.aspx or by calling OHP Customer Service at 1-800-699-9075 (TTY 711). Ask for the BCCTP Team.

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Assignment of rights to medical benefits
By asking for and receiving medical benefits, a person is giving to Oregon Health Authority (OHA) all rights to any medical support and to any third party payments for medical care. This allows OHA to seek payment from any third party liable to pay for the person's medical care.

Estate claim statement
Upon a person's death, the Oregon Department of Human Services and the Oregon Health Authority (ODHS|OHA) may take money from the person's estate *(as defined in ORS 414.104)*. The amount that can be taken is generally equal to the amount of medical benefits that a person received after age 55. If the person is permanently institutionalized *(as defined in OAR 461-135-0832)* at the time of death, medical benefits paid prior to age 55 may be recovered. The money to repay the medical benefits can be taken from the person's estate at the time of death. If the person has a surviving spouse, no claim will be made until his or her death. If there are surviving children under the age of 21, no claim will be made. If there are surviving children who are disabled, no claim will be made (ORS 115.125).

Social Security number
Social Security Numbers (SSN) are required for most people applying for medical benefits (42 USC Sec.1320b-7). The SSN will be used to:

- Make sure nobody gets benefits in more than one household;
- See which benefits a person can get;
- Make changes to large numbers of cases at one time;
- Recover overpaid benefits;
- Match our records against federal and state records. For example, Unemployment Compensation, Internal Revenue Service, Medicaid and Social Security records;
- Gather workforce information and research. This helps lawmakers and agencies improve services to Oregonians.

Non-Discrimination statement
The Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) do not discriminate against anyone. This means that ODHS|OHA will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs[1], disability or sexual orientation[2].

You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons. To file a complaint, you can call or write the Governor's Advocacy Office:

Governor's Advocacy Office
500 Summer Street NE, E17
Salem, OR 97301
503-945-6904, 1-800-442-5238, TTY 711
Email: DHS.INFO@ODHSOHA.OREGON.GOV
"Equal opportunity is the law!"

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[1]SNAP clients are protected against political belief discrimination.

[2]Sexual orientation is protected by the State of Oregon, but not federal laws.

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Rights of applicant

- To ask about OHA programs, payments and services.
- To apply for OHA programs.
- To get courteous and fair treatment without discrimination.
- To get reasonable accommodation for any disabilities per the Americans with Disabilities Act.
- To refuse to allow the release of information given to OHA unless it is required by law.
- To ask for and get a receipt for any forms given to OHA.
- To talk with a person in charge.
- To ask for a hearing on any action you disagree with. You have 45 days from the date of the notice to do this. The request must be on an Administrative Hearing Request form (DHS 443). This form is available from any OHA office. Someone at the office can help you fill it out.
- To know if you qualify for benefits within 45 days.

Responsibilities of applicant

- Give true, correct and complete information.
- Report the following changes within 10 days:
  - Changes of address;
  - Changes of other health care coverage (Medicare, private insurance, etc.);
  - Report if you become pregnant.
- Report changes by calling OHP Customer Service at 1-800-699-9075.
- Tell health care providers of other health care coverage before using your medical ID card.

By signing this application:

- I allow OHA to review my health care records. I allow OHA to share my health care records with OHA contractors and their providers.
- I understand the estate claim statement.
- I understand my rights and responsibilities as stated above.
- I understand the social security statement.

I affirm the information I have given in this application is true, correct and complete to the best of my knowledge.

This document can be provided upon request in alternative formats for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact Oregon Health Plan (OHP) at 1-800-699-9075 or TTY 1-800-735-2900

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Breast and Cervical Cancer Treatment Program (BCCTP) Application and Referral Form

Patient: Please complete the following section to apply for medical benefits from the BCCTP

Part 1 — Patient section

Applicant name:			Date:
Date of birth:	Social Security number:	Phone number:	Message phone:

Home address

Street:	City:	State:	ZIP code:

Mailing address: *(if different)*

Street:	City:	State:	ZIP code:

Family size: *(This includes yourself, your spouse and children if they live with you, and anyone else you include on your tax return)* _____

Total household gross monthly income: *(before taxes)* _____

Total taxable monthly deductions that can be claimed on your federal tax return _____

Are you a U.S. Citizen or National? ☐ Yes ☐ No

Are you a noncitizen with lawful immigration status? ☐ Yes ☐ No

Do you have any type of health insurance coverage? ☐ Yes ☐ No
This includes Medicare, private insurance, etc.

If yes, what type of coverage is it? *(Provide copy of insurance card, if available.)*

_____

The following questions will help us determine if you may qualify for another OHP program.

Are you a parent/relative of a child (under age 19) in your home?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Have you applied for disability benefits?	☐ Yes	☐ No
Have you been denied disability benefits?	☐ Yes	☐ No
Are you receiving disability benefits?	☐ Yes	☐ No

I have read my rights and responsibilities on pages 2 and 3. ☐ Yes ☐ No

_____ _____

(Signature of applicant) *(Date)*

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Provider: Once you've read the Application Guide and eligibility requirements, please complete the following section to make a presumptive BCCTP determination for this patient:

Part 2 — Provider section			
Provider name:	NPI number:	Specialty/license type:	
Clinic name:	Phone number:	Message phone:	
Street address:	City:	State:	ZIP code:

Diagnosis

Breast:	**Cervical:**
☐ Invasive breast cancer ☐ Ductal carcinoma in situ (DCIS)	☐ Persistent CIN 1 *(occurring over a period of at least 18 months)* ☐ CIN 2 or CIN 3 ☐ Invasive cervical cancer ☐ Adenocarcinoma in situ (AIS) ☐ Carcinoma in situ (CIS)

Date of diagnosis: _____

(This is the date of the procedure with which the cancer was diagnosed.)

Does patient have outstanding medical bills related to this diagnosis? ☐ Yes ☐ No

If yes, date that these bills began: _____

Would patient have met eligibility criteria on the above date? ☐ Yes ☐ No

I wish to receive the recipient's ID number expedited by phone: ☐ Yes ☐ No

Phone number: _____

Contact name: _____

By signing below, I affirm the patient meets the eligibility guidelines on page one of this application, the information listed in this section is true and complete and I am qualified to make this diagnosis.

_____ _____

(Signature of provider) *(Date)*

Fax completed form to: 503-373-7493