State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

Thank you for your interest in the Every Woman Counts (EWC) program. The EWC program provides free breast and cervical cancer screening services to women living in California.

The mission of the EWC program is to save lives by preventing and reducing the effects of breast and cervical cancer. The EWC program does this through education, early detection, and diagnosis. The EWC program is part of the Department of Health Care Services' Cancer Detection and Treatment Branch.

All parts of this application must be completed so the EWC program can decide if you are eligible to enroll in the EWC program.

You must be enrolled before the EWC program starts paying for covered services. Enrollment lasts for one year and then you must re-enroll. You can re-enroll with any EWC program Primary Care Provider (PCP).

Note:
- Pages 1, 2 and 3 are for you to read and keep.
- Pages 4, 5, and 6 must be completed so we can see if you are eligible.
- Pages 7, 8, and 9 are instructions for completing pages 4, 5, and 6. The EWC program PCP may also help you complete the application.
- Pages 10 and 11 are for use only by the EWC program PCP.

Privacy Statement

This application is to see whether you are eligible for services through the EWC program. It is your choice to complete this application. If the application is not complete, the EWC program may not be able to decide if you qualify for services. We may contact you if the application is not completed.

The EWC program may share your information with the EWC program PCP and other state, federal, and local agencies, as required by law.

You have the right to access records containing personal information that we maintain. For more information or to see records, please contact the EWC program at:

Department of Health Care Services
Benefits Division - Every Woman Counts Program
Attention: Division Chief
P.O. Box 997417, MS 4601
Sacramento, CA 95899-7417
(916) 449-5300

CA Revenue and Taxation Code sections 30461.6(f) and (j), and CA Health and Safety Code sections 104150(b), 104162, and 131085 authorize the EWC program to keep the information collected on this application. We must give you this Privacy Statement under CA Civil Code section 1798.17.

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

First Level Review and Formal Hearing Rights for the Every Woman Counts Program

You will be told if you are eligible for the EWC program or if you are not. If you do not agree with the eligibility decision, you have the right to ask for a first level review and/or formal hearing. You also have a right to a first level review and/or formal hearing if you disagree with the services you are getting under the EWC program.

You may not challenge the standards that the EWC program uses to make the eligibility decision. For example, if you think that the decision did not match the EWC program standards, you may ask for a first level review and/or formal hearing. But if you disagree with the EWC program standards, you may not ask for a first level review and/or formal hearing to try to change the EWC program standards.

If you wish to exercise your right to ask for a first level review and/or formal hearing, please submit a written request that includes the following:

- Your name, address and telephone number.
- The reason why you are requesting a first level review or formal hearing.
- Why you believe the decision is wrong.
- Your language preference, if you have trouble understanding English.
- The name, address, and telephone number of your authorized representative, if you choose to use one.

First Level Review: The written request for a first level review must be sent to the EWC program within 20 days of the decision you disagree with. Please keep a copy of your written request for your records. The EWC program will respond within 30 days of receipt of your request.

Mail your request for a First Level Review
Department of Health Care Services
Benefits Division - Every Woman Counts Program
Attention: Division Chief
P.O. Box 997417, MS 4601
Sacramento, CA 95899-7417

OR

Email your request for a First Level Review
CancerDetection@dhcs.ca.gov

The EWC program may contact you for more information. This contact may be by phone or in writing. The EWC program PCP may also be contacted for information.

Formal Hearing*:* The written request for a formal hearing must be sent to the Department of Social Services within 90 days of the decision you disagree with. If you have good cause why you were not able to file for a formal hearing within 90 days, you may still ask for a formal hearing to be scheduled. Please keep a copy of your written request for your records.

Mail your request for a Formal Hearing
Department of Social Services
State Hearings Division
P.O. Box 944243
Mail Station 9 – 17 – 37
Sacramento, CA 94244-2430

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

Notice of Nondiscrimination

DHCS complies with applicable Federal and State civil rights laws. DHCS does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

DHCS:

- Provides free aids and services to people with disabilities to communicate effectively with DHCS, such as:
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic formats and other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Office of Civil Rights, at **1-916-440-7370**, 711 (California State Relay) or email CivilRights@dhcs.ca.gov.

If you believe DHCS has failed to provide these services or you have been discriminated against in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with the Office of Civil Rights.

PO Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370, 711 (California State Relay)
Email: CivilRights@dhcs.ca.gov

If you need help filing a grievance, the Office of Civil Rights can help you. Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or you can file by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, TTY 1-800-537-7697

You can get a complaint form at:
http://www.hhs.gov/ocr/office/file/index.html

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

Tell us about you

1. First Name _____ 2. Middle Initial _____ 3. Last Name _____
4. Date of Birth (month / day / year) __ __ / __ __ / __ __ __ __
5. What is your sex? ☐ Female ☐ Male ☐ Transsexual: Male to Female ☐ Transsexual: Female to Male
6. Your Mother's Last Name When She Was Born (Maiden Name) _____
7. Address _____
8. City _____ 9. State _____ 10. Zip Code _____
11. Telephone number [(area code) number] (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
12. Email address _____
13. Social Security Number. List your number if you have one ___ ___ ___ - ___ ___ - ___ ___ ___ ___

The following information helps us decide if you are eligible for the EWC program.

Tell us about your household income.

We need to know how much money everyone in your household receives before paying taxes. If you file taxes, this is your "gross income."

14. Household income (before taxes and other deductions) $ _____
15. Total number of persons living on this income _____

Now let us know about your health insurance

☐ 16. I do not have health insurance.

☐ 17. I have health insurance or a healthcare plan but cannot afford the share-of-cost, deductible, or co-pay

My health insurance is ☐ 18. Medi-Cal ☐ 19. Name of Insurance _____
20. My card or policy number is _____

21. My share-of-cost is $ _____ per month.
22. My deductible is $ _____ per year.
23. My co-pay is $ _____ per visit.

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

What EWC services do you need? (check all that apply)

If you have any symptoms in your breasts, please check what they are:

- ☐ 24. Change in the look or feel of your breast(s), such as change of color, size or shape
- ☐ 25. Swelling or thickening of your breast(s) tissue
- ☐ 26. Discharge from your nipple
- ☐ 27. Lump or hard knot in your breast(s)
- ☐ 28. Other: _____
- ☐ 29. Are you 21 or older seeking cervical cancer screening?
- ☐ 30. Are you 40 or older seeking breast cancer screening?

Tell us about your use of tobacco

31. Do you smoke tobacco now? ☐ No ☐ Yes
32. Do you use other tobacco products now? ☐ No ☐ Yes; If Yes, what _____

This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide if you are eligible.

Tell us about your race

33. Are you Hispanic or Latina? ☐ Yes ☐ No

Select all that apply to you:

- ☐ 34. American Indian or Alaskan Native
- ☐ 35. Asian (Specify below)
  - ☐ 36. Asian Indian ☐ 37. Cambodian ☐ 38. Chinese ☐ 39. Filipino ☐ 40. Hmong
  - ☐ 41. Japanese ☐ 42. Korean ☐ 43. Laotian ☐ 44. Vietnamese ☐ 45. Other Asian: _____
- ☐ 46. Black or African American
- ☐ 47. Pacific Islander (Specify below)
  - ☐ 48. Guamanian ☐ 49. Hawaiian ☐ 50. Samoan ☐ 51. Other Pacific Islander: _____
- ☐ 52. White
- ☐ 53. Other: _____ ☐ 54. Prefer not to answer

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

The following information is confidential. It will not be used to decide if you are eligible.

Tell us about your gender identity and sexual orientation (Optional)

What is your gender? (check the box that best defines your current gender identity)

- ☐ 55. Female
- ☐ 56. Transgender: Male to Female
- ☐ 57. Male
- ☐ 58. Transgender: Female to Male
- ☐ 59. Non-binary (neither male nor female)
- ☐ 60. Another gender identity:_____

What sex was listed on your original birth certificate?

- ☐ 61. Female
- ☐ 62. Male

What do you think of yourself as?

- ☐ 63. Straight or heterosexual
- ☐ 64. Lesbian or gay
- ☐ 65. Bisexual
- ☐ 66. Queer
- ☐ 67. Another sexual orientation
- ☐ 68. Unknown

69. Declarations (Please read and initial each item)

_____ I understand that by signing this application, I am applying to the EWC program, which is a government-funded program. The EWC program pays for breast and/or cervical cancer screening services that may lead to a referral for treatment.

_____ This consent lasts for ONE YEAR from the date I sign it. I know that I must complete a new application each year to be in the EWC program.

_____ I understand I can stop being part of the EWC program at any time.

_____ If I obtain health insurance or other medical coverage, I will let the EWC program PCP know right away.

_____ I have received the **DHCS Notice of Privacy Practices** (NPP; not part of this application package).

_____ I have received the **Privacy Statement, First Level Review and Formal Hearing Rights,** and **Notice of Nondiscrimination** on pages 1, 2, and 3 of this application.

_____ I have received information about **how to get free or low-cost insurance.**

_____ I declare that the information that I have provided on pages 4, 5, and 6 is true and correct to the best of my knowledge. I understand that giving false information on this application may make me ineligible for the EWC program.

_____ I had help completing this application. 70. Name of who helped you_____

71. Signature of who helped, if applicable_____ 72. Date_____

Signatures

73. Yours _____ 74. Date_____

75. Person acting for EWC program applicant, if applicable_____ 76. Date_____

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION
DETAILED FORM INSTRUCTIONS FOR COMPLETING EWC RECIPIENT APPLICATION ON PAGES 4 THROUGH 6

Tell us about you

1. Write your first name.
2. Write the first letter of your middle name.
3. Write your last name.
4. Write your birthday. Use 2 numbers for the month, 2 numbers for the day, and 4 numbers for the year. For example, January 1, 2001 would be 01/01/2001.
5. If your physical sex is female, check female. If it is transsexual from male to female, check transsexual: male to female. If it is male, check male. If it is transsexual from female to male, check transsexual: female to male.
6. Write your mother's last name when she was born. This is also known as a maiden name.
7. Write the number and street name where you live. For example, 123 Main Street.
8. Write the city you live in.
9. Write the state you live in.
10. Write the zip code for where you live.
11. Write your telephone number. Start with the three numbers for the area code. Follow with the phone number.
12. Write your email address.
13. Write your Social Security Number, if you have one. You do not need a Social Security Number to be eligible for the EWC program.

Tell us about your household income

14. Enter the total amount of money that everyone in your home receives before they pay taxes. The amount of money a person makes before paying taxes is also known as the "gross income." Enter the total gross income for each person in your home who makes money.
15. Write down how many people are living on the income you entered in line 14.

Now let us know about your health insurance

16. Check this box if you do not have any health insurance.
17. Check this box if you do have health insurance or a health care plan.
18. Check this box if you have Medi-Cal.
19. Check this box if your insurance is not Medi-Cal. Write down the name of your health insurance company or health care plan.
20. Write down the number of your Medi-Cal card or write down your health insurance policy number. This number is often on your insurance card.
21. Write down how much you must pay each month for your Medi-Cal share-of-cost, if you have to pay a share-of-cost.
22. Write down how much you must pay each year for your health insurance or health care plan's annual deductible, if you have to pay a deductible.
23. Write down how much you must pay as a co-payment for each medical appointment covered by your health insurance or health care plan, if you have to pay a copayment.

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

What EWC services do you need? (check all that apply)

24. Check this box if your breast(s) color, size or shape has changed.
25. Check this box if there is any swelling or thickening of your breast(s) tissue.
26. Check this box if there is any discharge from your nipple.
27. Check this box if there is a lump or hard knot in your breast(s) that you can feel.
28. Check this box if your breast(s) have another symptom. Write down the symptom.
29. Check this box if you are over 21 years of age and would like to be screened for cervical cancer.
30. Check this box if you are over 40 years of age and would like to be screened for breast cancer.

Tell us about your use of tobacco

31. If you do not smoke tobacco, check the No box. If you do smoke tobacco, check the Yes box.
32. If you do not use other tobacco products, check the No box. If you do use other tobacco products, check the Yes box and then write down what tobacco products you use.

Tell us about your race

33. If you are Hispanic or Latina, check the Yes box. If you are not Hispanic or Latina, check the No box.
34. Check this box if your race is all or part American Indian or Alaskan Native.
35. Check this box if your race is all or part Asian and then check a box for which part of Asia (boxes 37-46).
36. Check this box if your race is all or part Asian Indian.
37. Check this box if your race is all or part Cambodian.
38. Check this box if your race is all or part Chinese.
39. Check this box if your race is all or part Filipino.
40. Check this box if your race is all or part Hmong.
41. Check this box if your race is all or part Japanese.
42. Check this box if your race is all or part Korean.
43. Check this box if your race is all or part Laotian.
44. Check this box if your race is all or part Vietnamese.
45. Check this box if your race is all or part of another Asian race. Then write the Asian race.
46. Check this box if your race is all or part Black or African American.
47. Check this box if your race is all or part Pacific Islander and then check one of the boxes for which Pacific Island (boxes 49-52).
48. Check this box if your race is all or part Guamanian.
49. Check this box if your race is all or part Hawaiian.
50. Check this box if your race is all or part Samoan.
51. Check this box if your race is all or part Other Pacific Islander. Then write the Pacific Island.
52. Check this box if your race is all or part White.
53. Check this box if your race is all or part of a race that is not listed. Then write the race.
54. Check this box if you do not want to state your race.

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

Tell us about your gender identity and sexual orientation (Optional)

55. Check this box if you identify as a female.
56. Check this box if you identify as a female but were identified as a male at birth.
57. Check this box if you identify as a male.
58. Check this box if you identify as a male but were identified as a female at birth.
59. Check this box if you do not identify as either a female or a male.
60. Check this box if you identify as a gender that is not listed. Please write down that gender.
61. Check this box if your original birth certificate listed your sex as female.
62. Check this box if your original birth certificate listed your sex as male.
63. Check this box if your sexual orientation is straight or heterosexual (sexually attracted to people of the opposite sex).
64. Check this box if your sexual orientation is lesbian or gay (sexually attracted to people of the same sex as you).
65. Check this box if your sexual orientation is bisexual (sexually attracted to both males and females).
66. Check this box if your sexual orientation is queer (not exclusively heterosexual).
67. Check this box if your sexual orientation is not listed in this section.
68. Check this box if you do not know your sexual orientation.

Declarations

69. Write your initials on each line after you read it and agree that what it says is true.
70. Write down the name of the person who helped you fill out this application, if someone helped you.
71. The person who helped you fill out the application will sign their name.
72. Write down today's date.
73. Sign your name.
74. Write down today's date.
75. If someone is acting for you (the EWC program applicant) as an authorized agent, they will sign their name.
76. Write down today's date.

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION
FOR OFFICE USE ONLY

EWC PROGRAM APPLICANT/RECIPIENT ELIGIBILITY VERIFICATION CHECKLIST

1. EWC Program Applicant/Recipient Name_____

2. Medical Record Number _____ 3. Recipient ID __ __ 9 A _ _ _ _ _ _ _ _ _ _

I have determined that this EWC program applicant/recipient meets the following eligibility criteria:

Residency

☐ 4. Lives in California

Household Income

☐ 5. Household Income is at or below 200% of the Federal Poverty Level. Please refer to the EWC Income Criteria on the EWC program website: http://dhcs.ca.gov/EWC

Health Insurance

☐ 6. Is uninsured

☐ 7. Is underinsured
- ☐ 8. Unmet share-of-cost
- ☐ 9. Co-payment(s)
- ☐ 10. Unmet deductible(s)

EWC program services

☐ 11. Needs breast cancer diagnostic services—symptomatic EWC program applicant/recipient, any age

☐ 12. Needs breast and/or cervical cancer screening and is the appropriate age for the service(s).

Tobacco Use

☐ 13. I have notified the PCP to assess the EWC program applicant/recipient's tobacco status, and to refer the EWC program applicant/recipient to tobacco cessation resources, as necessary.

I have provided this EWC program applicant/recipient with the following:

☐ 14. DHCS Notice of Privacy Practices.

☐ 15. Privacy Statement, First Level Review and Formal Hearing Rights, and Notice of Nondiscrimination: pages 1, 2 and 3 of the application.

☐ 16. Brochure about how to get free and low-cost health insurance.

17. Provider/Staff Signature_____ 18. Date_____

19. Print Name _____

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

DETAILED FORM INSTRUCTIONS FOR COMPLETING RECIPIENT ELIGIBILITY VERIFICATION CHECKLIST ON PAGE 10

EWC Program Applicant Information

1. Write the EWC program applicant/recipient's name as it is written on the DHCS 8699 (Rev. 1/19) application.
2. Write the EWC program applicant/recipient's Medical Record Number.
3. Write the EWC program applicant/recipient's assigned Recipient ID.
4. Check this box if the EWC program applicant/recipient lives in California.
5. Check this box if the EWC program applicant/recipient's household income is at or below 200% of the Federal Poverty Level based upon the number of people living in the household. The current Federal Poverty Guidelines to apply are on the EWC program website: (http://dhcs.ca.gov/EWC).
6. Check this box if the EWC program applicant/recipient is uninsured (does not have health insurance).
7. Check this box if the EWC program applicant/recipient is underinsured (has health insurance or a healthcare plan but cannot afford the share of cost, deductible or co-pay).
8. Check this box if the EWC program applicant/recipient has an unmet share-of-cost.
9. Check this box if the EWC program applicant/recipient must make co-payments for visits.
10. Check this box if the EWC program applicant/recipient has an unmet deductible(s).
11. Check this box if the EWC program applicant/recipient has breast cancer symptoms and needs diagnostic services.
12. Check this box if the woman EWC program applicant/recipient is over age 21 and needs cervical cancer screening and diagnostic services and / or if the EWC program applicant/recipient is over age 40 and needs breast cancer screening and diagnostic services.
13. Check this box if you alerted the PCP regarding the EWC program applicant/recipient's tobacco use.
14. Check this box if you gave the EWC program applicant/recipient a DHCS Notice of Privacy Practices.
15. Check this box if you gave the EWC program applicant/recipient the Privacy Statement, First Level Review and Formal Hearing Rights, and Notice of Nondiscrimination from the first three pages of the application.
16. Check this box if you gave the EWC program applicant/recipient information about how to get free and low-cost health insurance.
17. Sign your name.
18. Write today's date.
19. Print your full name.