Medicaid Cancer Treatment Program Application

Breast, Cervical, Colorectal and Prostate Cancer

New York State Department of Health

Instructions

CONFIDENTIALITY STATEMENT

All of the information you provide on this application will remain confidential. The only people who will see this information are the Cancer Services Program Partnerships (CSPP), the State Department of Health, or local Department of Social Services who need to know this information in order to administer the Medicaid Program. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State Department of Health which needs this information.

PLEASE READ the entire application, instructions and document checklist before you fill out the application. (Refer to the documentation checklist for acceptable required documents.) If you need more space to list information, use the Additional Information section.

Social Security Number. A social security number must be provided for all persons applying. If you do not have a social security number you must apply for one.

Race/Ethnic Affiliation. This information is optional. It is asked to make sure all people have access to the program. If you fill out this information, check the box on the application that best describes your race or ethnic background.

Section A:

APPLICATION SHOULD BE FILLED OUT BY THE CSPP STAFF AND APPLICANT

Section B: PERSONAL DATA

In this section, we ask for information about how to contact the applicant. The home address is where the person applying for health insurance lives. The mailing address, if different, is where the Benefit Identification Card and all notices will be sent. Please include apartment number.

Section C: HOUSEHOLD INFORMATION

These questions help us determine which program is best for the applicant. You may be eligible for Medicaid under one of the other Mandatory Medicaid Categorical groups.

1) Indicate if you are pregnant. Indicate the date the baby is due.
2) Fill out the information requested for each dependant child under 21 years of age living in the household.
3) To determine your household composition, it is important for us to know if the child's parent or your spouse is living in the home.
4) Indicate your monthly housing payment, type of heat and if the heat is included in the rent.
5) Answer YES if you consider yourself disabled or you receive cash benefits based on a disability.
6) It is important to tell us whether you have health insurance or are covered by someone else's insurance. If you are covered by health insurance, you must provide documentation that breast, cervical, colorectal and/or prostate cancer services are not covered by your insurance.
7) Applicants must show proof of satisfactory U.S. citizenship or immigration status.

To be eligible for the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer (MCTP) persons must be a U.S. Citizen, National, Native American or fall into one of many immigration categories. ***Temporary Workers, Visitors or Foreign Students are not eligible for the MCTP.***

A person with satisfactory immigration status will fall under one of the following:

- Legal Permanent Resident (green card holder)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Withholding of Deportation
- Conditional Entrant
- Parolee at least one year
- Native American born in Canada who is at least 50% Native American
- Battered/Abused immigrants
- Order of Supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action Status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Property filed or granted application for adjustment of status
- Has continuously lived in the United States since before January 1, 1972
- Living in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure the federal immigration agency does not contemplate enforcing.

The State will not report any information on this application to the federal immigration agency.

Instructions continued on the inside back page

Instructions (continued)

8) At the time of the interview, you will be asked about the total amount of money received each month from wages, salaries, tips, Social Security benefits, disability benefits, unemployment benefits, veteran's benefits, alimony, or rental income. If you have no income, please indicate none. Please include any money that anyone gives you each month to help meet living expenses. This information will be used for the purpose of determining if you might be eligible for Medicaid under one of the Mandatory Medicaid Categorical groups.

9) At the time of the interview, you will be asked about the total value of your resources. Examples of resources include such things as money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, or property that someone owns. Do not count the value of your home. The value of your resources does not make you ineligible for the MCTP, but this information will be used for the purpose of determining if you might be eligible for Medicaid under one of the Mandatory Medicaid Categorical groups.

10) Please indicate if you are receiving Cash Assistance, Supplemental Security Income (SSI), Medicaid, Medicare or other financial assistance.

11) Is anyone in the household on full time duty in the U.S. Army, Navy, Air Force, Marine Corps, Coast Guard or a veteran of the Armed Forces? Answer yes or no and enter the person's name on the line provided.

Section D: RETROACTIVE MEDICAID

If you have paid or unpaid medical bills from the past 3 months, MCTP may be able to pay for these costs. If you want us to determine your eligibility for retroactive Medicaid coverage, check the appropriate box. Include copies of medical bills with this application.

Section E: APPLICANT RELEASE AGREEMENT

By signing this agreement you give permission for the information on this application to be shared with the State Medicaid Program, NYS Medicaid Cancer Treatment Program, the local Department of Social Services, the NYS Cancer Services Program and the Cancer Services Program Partnerships. The information is being shared for the purpose of administering the Medicaid Program.

Section F: NYS BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER SCREENING AND DIAGNOSIS CERTIFICATION

This section is to be completed by the New York State Department of Health's Cancer Services Program.

Section G: MEDICAL REFERRAL

Have your health care provider complete the medical information portion of this form and return it to the Cancer Services Program Partnerships by the date indicated below.

Section H: APPLICANT RELEASE AGREEMENT

You must sign the release agreement on the Medical Referral Form. By signing this medical information release, you give permission for your health care provider to share your personal medical information with the State Medicaid program, New York State Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer, the local Department of Social Services, the Cancer Services Program Partnerships, and the Cancer Services Program.

Your application cannot be completed until all required items are received.

Please return these items by _____.

If you need help getting any of these items, contact your Cancer Services Program Partnership.

Terms, Rights and Responsibilities

By completing and signing this application, I am applying for the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer. I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid, I will tell the Cancer Services Program Partnerships. The Cancer Services Program Partnerships may be able to help in getting the information.
- I understand that workers from the programs for which I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307 and any federal and state laws and regulations.
- I understand that Medicaid will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid I am giving to the Medicaid agency all of my rights to receive medical support from a spouse or parents of persons under 21 years old and my right to third party payments for the entire time I am on Medicaid.
- I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties.

CSPP Name and Address

State of New York
Department of Health

DOCUMENTATION CHECKLIST for Health Insurance

All documentation must be included for the application to be considered complete.

Applicant Name_____ **Application Date**_____

PROOF OF IDENTITY/CITIZENSHIP/DATE OF BIRTH AND RESIDENCY

You must show documentation of identity, citizenship, date of birth and residency to see if you are eligible for health insurance. For identity/citizenship documentation the Cancer Services Program Partnerships (CSPP) must see the original document or a document certified by the issuing agency. CSPP will make copies of the document and annotate on the copy that they saw the original. You may discuss this with the person helping you with your application.

IDENTITY/CITIZENSHIP/DATE OF BIRTH**

- ☐ Driver's license/Official photo identification
- ☐ U.S. Passport*
- ☐ Birth certificate
- ☐ Baptismal/other religious certificate
- ☐ Official school records
- ☐ Adoption records
- ☐ Official hospital/doctor birth records
- ☐ Certificate of U.S. Citizenship*
- ☐ Certificate of Naturalization*
- ☐ Marriage records

** Satisfies both identity and citizenship documentation.*

RESIDENCY/HOME ADDRESS*

- ☐ ID card with address
- ☐ Postmarked envelope, postcard, or magazine label with name and date (no P.O. Box)
- ☐ Drivers license issued within past 6 months
- ☐ Letter/lease/rent receipt with home address from landlord
- ☐ Property tax records or mortgage statement
- ☐ Utility bill (gas, electric, cable), bank statement or correspondence from a government agency which contains a street address (not a P.O. Box)

**This must match the home address in Section B and the proof must be dated within 6 months of the application.*

***See DOH 4418 for additional documents for identity/citizenship.*

INCOME

- ☐ Current wage stubs
- ☐ Current award letterr
- ☐ Current benefit check
- ☐ Income tax records/return (schedule C)
- ☐ Correspondence from employer
- ☐ Other _____

ADDITIONAL INFORMATION

If necessary, this section may be used to record additional information.

IMMIGRATION DOCUMENTS

If not a U.S. Citizen, please give the following information. Your answers to these questions will be kept completely confidential.

Cancer Services Program Partnerships (CSPP) must see the original document or a document certified by the issuing agency. CSPP will make copies of the document and annotate on the copy that they saw the original.

First Name	M.I.	Last Name	**Does this person belong to any of the categories listed below?** ***Check the appropriate box.***	**If box A is checked, enter Date of Status (DOS)** (mm/dd/yyyy)	**If either A or B, enter date when the person entered the U.S. (DEC)** (mm/dd/yyyy)
			☐ A ☐ B ☐ C ☐ None		
			☐ A ☐ B ☐ C ☐ None		
			☐ A ☐ B ☐ C ☐ None		

Check A if the person is under one of the following categories:

- Lawful Permanent Resident (green card holder)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Parolee for at least one year
- Withholding of Deportation
- Conditional Entrant
- Native American born in Canada who is at least 50% Native American
- Some battered/abused immigrants

Check B if the person is under one of the following categories:

- Order of Supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action Status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Properly filed or granted application for adjustment status
- Has lived continuously in the United States since before January 1, 1972
- Living in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure the federal immigration agency does not contemplate enforcing

Check C if the person is a non-immigrant*

Short term visa holders such as:

- Foreign students
- Visitors
- Temporary workers

*Temporary Workers, Visitors or Foreign Students are not eligible for the MCTP (Column C). The State will not report any information on this application to the federal immigration agency.

Section A CSPP INFORMATION - TO BE COMPLETED BY SITE STAFF

CSPP Name _____ CSPP # ☐☐

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

CSPP Contact Person _____ Phone ( ) _____

Section B PERSONAL DATA - TO BE COMPLETED BY SITE STAFF AND APPLICANT

Name _____ (FIRST) (MI) (LAST) (MAIDEN) SSN # _____

Date of Birth ____/____/____/ Marital Status _____ Sex: M F CSPP Client # _____

Address _____ (STREET) (CITY) (STATE) (ZIP)

Mailing Address (if different from above) _____ (STREET/ P.O. BOX) _____ (CITY) _____ (STATE) _____ (ZIP)

Client Phone # ( ) _____ Primary Language _____ County of Residence _____

Race/Ethnic Affiliation: (optional)

☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White

☐ American Indian or Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____

Section C HOUSEHOLD INFORMATION (The following questions are being asked to determine if you might be eligible under one of the Mandatory Medicaid Categorical Groups.

1. Are you pregnant? Yes No If **Yes**, Due Date

2. Do you have dependent children under the age of 21 who live with you? ☐ Yes ☐ No

   If **Yes**, list their names and dates of birth.

   Name _____ DOB _____ Name _____ DOB _____

   Name _____ DOB _____ Name _____ DOB _____

   Do you pay childcare expenses? ☐ Yes ☐ No

   If **Yes**, $_____ ☐ Weekly ☐ Monthly

3. Does your spouse or the parent of your children live in your home? Yes No

4. What is your monthly housing payment? $_____

   Type of heat (gas, oil, etc.) _____ Is heat included in your housing payment? ☐ Yes ☐ No

5. Have you been determined to be disabled by the Social Security Administration or your County/State Medical Review Team? Yes No

6. Do you have health insurance? If **Yes**, attach a copy of the insurance card. ☐ Yes ☐ No

   Does this insurance provide coverage for treatment of breast, cervical, colorectal or prostate cancer? ☐ Yes ☐ No

   What is the monthly cost of this insurance coverage? $_____

7. Are you a United States citizen, national, Native American or an alien with satisfactory immigration status? If **Yes**, attach a copy of proof of citizenship/national, or alien status. Yes No

8. How much is your household income? Check the type(s) of money and the amount received:

   Earnings From Work: ☐ Weekly ☐ Bi-weekly ☐ Monthly

   Wages/Salaries $_____ Commissions $_____ Tips $_____

   Overtime $_____ Self-employment $_____ Other $_____

   Unearned Income: (Indicate the **monthly** amount)

   Social Security Benefits $_____ Disability Payments $_____

   Unemployment Benefits $_____ Veteran's Benefits $_____

   Worker's Compensation $_____ Child/Support Payments $_____

   Alimony $_____ Rental Income $_____

   Interest and Dividends $_____ Other $_____

   Contributions (money received each month from friends, family or anyone that help meet living expenses) $_____

   Total Gross Monthly Income (earned and unearned) $_____

9. Check all resources that you may have. Resources include:

Cash on hand
Saving/Checking Account(s)
Life Insurance
Real Property (other than your home)
Stocks/Bonds/Certificates/Mutual Funds
IRA/Keogh/401-K or Deferred Compensation Accounts
Burial Trust/Burial Fund
Resources other than those listed above: _____

Total Value of Resources $ _____

10. Are you currently receiving any other assistance? If **Yes**, check all that apply. ☐ Yes ☐ No

☐ Financial assistance ☐ Medicaid ☐ Medicare (A, B or D) ☐ SSI ☐ Other _____

11. Is anyone in the household a veteran? Yes No

If **Yes**, Name _____

Section D APPLICATION FOR RETROACTIVE MEDICAID

Otherwise eligible individuals who have paid or unpaid medical bills may qualify for up to three 30-day periods of coverage before the application date. This is called "Retroactive Medicaid".

Do you wish to apply now for Retroactive Medicaid? Yes No

If **Yes**, for which period? Check one:

within 30 days ☐
between 30 and 60 days ☐
between 60 and 90 days (of application date) ☐

Section E APPLICANT RELEASE AGREEMENT

I agree that the information on this application may be shared only with the State Medicaid Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer, the local Department of Social Services, the Cancer Services Program Partnerships and the NYS Cancer Services Program providing the application assistance. I understand that this information is being shared for the purpose of administering the Medicaid Program.

I have read and understand the Terms, Rights and Responsibilities included in this application booklet. I certify, under penalty of perjury, that the information I have provided on this application is true and complete to the best of my knowledge.

_____
PRINT YOUR FULL NAME

_____ _____ _____ _____
APPLICANT SIGNATURE DATE WITNESS SIGNATURE DATE

Section F MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL AND PROSTATE SCREENING CERTIFICATION

The Cancer Services Program certifies that the patient named above meets all the CSP eligibility criteria for screening, has received such screening and/or diagnosis and is in need of treatment for breast, cervical, colorectal and/or prostate cancer.

_____ _____
NYS HEALTH PROGRAM COORDINATOR DATE

Section G MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER HEALTH INSURANCE MEDICAL REFERRAL

CSPP # ☐ ☐ CSPP Client # _____

Facility/Clinic _____ Phone ( ) _____

Address _____ Contact Person _____

Patient Name _____ Date of Birth _____

Patient Address _____ SSN _____

Patient Phone Number ( ) _____

Diagnosis

☐ Cervical Pre–Cancerous Lesion (if subsequent treatment is required)

☐ Cervical In Situ

☐ Cervical Invasive

☐ Atypical Ductal Hyperplasia (ADH) (if subsequent treatment is required)

☐ Breast Lobular Carcinoma In Situ (if subsequent treatment is required)

☐ Breast In Situ

☐ Breast Invasive

☐ Colorectal Pre-Cancerous (if subsequent treatment is required))

☐ Colorectal In Situ

☐ Colorectal Invasive

☐ Prostate Atypia

☐ Prostate High Grade Prostatic Intraepithelial Neoplasia (HGPIN)

☐ Prostate Invasive

Date of Diagnosis from original biopsy _____/_____/_____/
MONTH DAY YEAR

Diagnosis/Staging (if available) _____

Treatment Plan _____

Estimated Length of Treatment (in months) _____

PHYSICIAN, NURSE PRACTITIONER, OR LICENSED PHYSICIAN ASSISTANT (SIGNATURE) DATE

PHYSICIAN, NURSE PRACTITIONER, OR LICENSED PHYSICIAN ASSISTANT (PRINT NAME)

Please sign and return form to:

By _____

Section H APPLICATION RELEASE AGREEMENT

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I agree that the information on this medical referral may be shared only with the State Medicaid Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer, the local Department of Social Services and the Cancer Services Program Partnerships and the Cancer Services Program providing the application assistance. I understand that this information is being shared for the purpose of determining my eligibility for Medicaid. I also agree that the information released may include HIV, mental health, or alcohol and substance abuse information about me to the extent permitted by law.

PRINT YOUR FULL NAME

APPLICANT SIGNATURE DATE WITNESS SIGNATURE DATE