Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

FINANCIAL ELIGIBILITY

Client Name: _____ Date of Birth: _____ ID#_____

1. Do you have Medicaid? ☐ YES ☐ NO **OR** Do you have Medicare? ☐ YES ☐ NO
2. Do you have any form of health insurance? ☐ YES ☐ NO Name of insurance _____
3. **Number of people in your Household.** _____ (include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes): $**_____ Month **OR $**_____ Year

Family Size	2021 DOH Scale Monthly Income	2021 DOH Scale Yearly Income
1	$2,146.58	$25,759.00
2	$2,903.25	$34,839.00
3	$3,659.91	$43,919.00
4	$4,416.58	$52,999.00
5	$5,173.25	$62,079.00
6	$5,929.91	$71,159.00
7	$6,686.58	$80,239.00
8	$7,443.25	$89,319.00
9	$8,199.91	$98,399.00
10	$8,956.58	$107,479.00

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:

If I obtain health insurance coverage, while under the FBCCEDP, it is my responsibility to notify the REGIONAL FBCCEDP office as soon as possible.

Signature _____

Date _____

If you have any questions Please call the regional coordinator at (386) 326-3281/Department of Health Putnam County between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.