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	2023 DOH Scale Monthly Income	2023 DOH Scale Yearly Income
1	$2,429.91	$29,159.00
2	$3,286.58	$39,439.00
3	$4,143.25	$49,719.00
4	$4,999.91	$59,999.00
5	$5,856.58	$70,279.00
6	$6,713.25	$80,559.00
7	$7,569.91	$90,839.00
8	$8,426.58	$101,119.00
9	$9,283.25	$111,399.00
10	$10,139.91	$121,679.00

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________________________________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.