Florida Breast and Cervical Cancer Early Detection Program (FBCC)

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	2026 DOH Scale Monthly Income	2026 DOH Scale Yearly Income
1	$2,659.91	$31,919.00
2	$3,606.58	$43,279.00
3	$4,553.25	$54,639.00
4	$5,499.91	$65,999.00
5	$6,446.58	$77,359.00
6	$7,393.25	$88,719.00
7	$8,339.91	$100,079.00
8	$9,286.58	$111,439.00
9	$10,233.25	$122,799.00
10	$11,179.91	$134,159.00

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 FBCC, it is my responsibility to notify the REGIONAL FBCC office as soon as possible.

Signature_____

Date _____

If you have any questions, please call the regional coordinator at 904-253-1610 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.