



# 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 (386)326-3281 or (386)326-3220 Message 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.