

**Breast and Cervical Cancer Treatment Program
Continuing Eligibility Redetermination**

California State law requires you to give Breast and Cervical Cancer Treatment Program (BCCTP) the information below at least once a year. This is to make sure you still qualify for Medi-Cal under the BCCTP. To keep your Medi-Cal benefits with BCCTP, fill out this form. Include all information needed to redetermine (review) your eligibility.

Form Instructions

1. Write your answers in ink.
2. Complete, sign, and date this form.
3. Have your doctor fill out and sign a Physician Statement of Certification (PSC) to verify you still require treatment for breast and/or cervical cancer.
4. Return this form and the PSC form by email, fax, or mail using the contact information below.

If BCCTP does not receive your completed form and all necessary documents by the redetermination due date, your BCCTP benefits may end. If you missed the due date and wish to keep your BCCTP benefits, or if you have questions or need assistance filling out this form, contact your BCCTP Eligibility Specialist by telephone at 1-800-824-0088.

BCCTP Member Information

Case Tracking Number (to be completed by BCCTP):			
(Print Name) Last:	First:	Middle Initial:	
Daytime Phone Number (include area code):			
<input type="checkbox"/> Check here if BCCTP can leave on this line. If not, please provide another phone number below where BCCTP may leave a message.			
Message Phone Number (include area code):			
Current home address:	City:	State:	Zip Code:
<input type="checkbox"/> Check here if this is a different address than what you reported during your prior redetermination.			

BCCTP Member Eligibility Information

1. Do you have other healthcare coverage or insurance, including Medicare? Yes No

If yes, attach a copy of the front and back of your health insurance card and a copy of your health insurance’s Explanation of Benefits and answer the questions below.

- a. How many people are on the plan?
- b. What is the premium paid each month? \$

2. Has your citizenship or immigration status changed since your prior redetermination?

Yes No

If **yes**, attach a clear copy of the front and back of the document supporting your statement of citizenship, noncitizen, and/or immigration status. *Documentation examples include a Certificate of Naturalization, a Permanent Resident card, immigration document, etc.*

3. What is your monthly gross household income (income before taxes, deductions, or any other expenses)? \$
4. How many people are in your household? (Number of people)

Household includes you (B C C T P member), all dependent children under age 21 who live in your home, your spouse and/or your child’s other parent if living in your home.

List your household members in the table below.

Name (First and Last)	Date of Birth	Relationship to You (spouse, partner, child)

CASE Tracking Number (to be completed by BCCTP):

Signature and Certification

I declare under the laws of the State of California that I have read and understand all information requested on this form and my responses and documents are true and correct to the best of my knowledge.

Signature of BCCTP Member	Date:
Signature of Witness (if BCCTP member signed with a mark)	Date:
Signature of Person Acting on Behalf of the BCCTP Member	Date:
Phone Number:	Relationship to Member:

What happens if you do not return this redetermination packet?

If we do not have your completed forms and the information we need by the due date, your BCCTP benefits may end. If you missed your due date and want to keep your BCCTP benefits, call your Eligibility Specialist today.

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