

**Breast Cancer Treatment Support Project
Enrollment Form**

Application Date:

____/____/____

Patient Contact Information

First Name: _____ Last Name _____ Middle
Initial ____

Mailing Address:

City _____ State ____ Zip Code _____ Phone ()

E-mail: _____

Patient Demographic Information

DOB: ____/____/____

Gender: ____M ____F

Race/Ethnicity: ____American Indian/Alaska Native ____Asian/Pacific Islander
____Black ____Hispanic/Latina(o) ____White ____Other/more than one

Health Insurance: ____None ____Private Insurance (HMO, PPO, POS, etc.)
____Public Insurance (Medicare, Medicaid, VA, County assistance, BCCSP, MVP, etc.)

Number of people in household _____ Annual household
Income _____

- I hereby certify that the information I have provided is accurate.
- I give permission to the Health Council of West Central Florida to contact me regarding my experience with this program.

Patient Signature

Patient Advocate Information

Advocate's Name _____ Phone: () -

Agency/Facility _____ Fax: () -

Address _____

City _____ State ____ Zip _____ e-mail: _____

Type of Facility: ____Screening Program ____Public Care Program ____Hospital
____Private Physician ____Cancer education/advocacy ____Other

- I have verified that patient is a resident of _____ County and is currently in treatment for breast cancer.
- The information provided regarding family income meets the criteria for program eligibility (350% FPL).

Signature of Advocate

Return to: HCWCF Fax: (727) 570-3033