SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Application Addendum - Breast & Cervical Cancer Program

things to know

General Information

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 allows states to provide full Medicaid benefits to individuals who are found to be in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia). This coverage group is known as the Breast and Cervical Cancer Program (BCCP). The following criteria must be met:

- The individual is an adult under age 65;
- The individual must meet SC state residency, citizenship/alienage, and identity requirements;
- The individual does not have other insurance coverage that would cover treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia), including Medicare Part A or B;
- The individual's family income is at or below 200% of the Federal Poverty Level; and
- The individual is not eligible for another Medicaid eligibility group.

Application Process

Upon being diagnosed with breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia) an individual can apply for coverage in the following manner:

1. Complete and sign the Application for Healthy Connections Medicaid (DHHS Form 3400) or apply online at www.scdhhs.gov. The medical provider rendering the diagnosis must complete Form 913-A.
2. The provider rendering the diagnosis must complete and sign the relevant sections on Page 2.
3. The completed application and addendums are faxed to the Breast and Cervical Cancer Program at (803) 255-8237. A Pathology Report indicating the diagnosis and a copy of the applicant's insurance card must be faxed with the application. Note: A cytology report (Pap Smear) is not sufficient.
4. The applicant will be notified in writing of approval or denial of the application. Individuals who qualify are eligible for the full range of Medicaid coverage.
5. Coverage continues as long as eligibility criteria are met and the beneficiary continues treatment. The beneficiary must report to their Medicaid worker when treatment is completed.
6. Eligibility is reviewed annually for individuals with breast or cervical cancer and bi-annually (every six months) for individuals with pre-cancerous lesions. When it is time for the review, a review form is mailed to the beneficiary and must be returned or coverage will stop.
7. Once treatment is completed, the beneficiary must qualify under another Medicaid program for coverage to continue.
8. If you have questions regarding the BCCP, or need help in completing this addendum, please call: 1-888-549-0820 (TTY 1-888-842-3620).

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Section I - Applicant Information

Applicant Name (First name, Middle name, Last name) (Print)		Phone	
Street Address	City	State	ZIP
Medicaid ID (if applicable)	Date of Birth	Today's Date	

Section II - Best Chance Network (BCN) Referral

Only complete this section if the applicant is a Best Chance Network Patient. If not BCN please leave this section blank.

BCN Screening Provider Site	Date of BCN Screening
BCN Provider Representative Name (Print)	BCN Provider Representative Signature

Section III - Medical Provider / Non-BCN Referral

Provider Referring Patient to Medicaid (Print)		Phone Fax	
Street Address	City	State	ZIP

Signature

Has the patient applied for Medicaid? ☐ Yes ☐ No

To request an application, call (888) 549-0820 or visit www.scdhhs.gov

Has the patient received treatment for one of the following: ☐ Yes ☐ No

•*Breast cancer* •*Cervical cancer* •*Atypical Breast Hyperplasia* •*Precancerous Cervical Lesion (CIN 2/3)*

Date of Diagnosis: _____

Has the patient received treatment for this diagnosis in the past 3 months? ☐ Yes ☐ No

Did the patient have insurance coverage for these expenses? ☐ Yes ☐ No

Is the patient in need of continued treatment? *If yes, please send current office notes.* ☐ Yes ☐ No

Section IV - Authorization to Disclose Health Information - Completed by Applicant

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) to DHEC of all my medical records, education records and other information related to my BCCPTA application.

Signature of Applicant / Beneficiary

Section V - DHEC Office Information

DHEC Employee Assisting with Application (First name, Middle name, Last name)

DHEC Employee Phone Number	DHEC Employee Email
Nurse Case Manager Name (Print)	Nurse Case Manager Signature

Mail to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 **Fax to: 803-255-8237**

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Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။