ITEMS NEEDED FOR PROCESSING DELAWARE CANCER TREATMENT PROGRAM (DCTP) APPLICATION

- DCTP APPLICATION COMPLETED, SIGNED, AND DATED

- PROOF OF INCOME
  *must be submitted for ANYONE living in the household
  - 3 consecutive pay stubs
  - Social security income document
  - Department of Labor unemployment income document
  - Workers compensation income
  - Self-employed – 1040 tax form

- LEGIBLE COPY OF DRIVERS LICENSE OR STATE ID

- MARKETPLACE APPLICATION APPROVAL OR DENIAL
  *You only need to submit the first TWO pages of the document
  - To apply call 1-800-318-2596
    or visit www.healthcare.gov

- COMPLETED DCTP CERTIFICATE OF DIAGNOSIS
  - Your treating physician must fill this out

- PROOF OF RESIDENCY AT TIME OF DIAGNOSIS
  *Driver's license, rental lease, or utility bill

If you need assistance in completing the application process, please call: 1-844-245-9580 and select option 3

Delaware Cancer Treatment Program
Division of Public Health
C/O DXC
P.O. Box 950 Manor Branch
New Castle, DE 19720-0950
1-844-245-9580
Fax 302-454-0223

Dear Delaware Resident:

Enclosed you will find an application form for the Delaware Cancer Treatment Program (DCTP), a program of the Delaware Health and Social Services (DHSS), Division of Public Health. The DCTP pays for cancer treatment services for eligible clients for a period of up to 24 months after the date that cancer treatment is initiated, **when services are provided by a Delaware Medical Assistance Provider.**

This program is available to Delaware residents who:

- Were diagnosed with cancer on or after July 1, 2004
- Have no comprehensive health insurance OR maximum out-of-pocket expenses are more than 15 percent of income (does not include premiums)
- Do not receive benefits through the Medicaid breast and cervical cancer treatment program
- Meet income guidelines (up to 650 percent of the Federal Poverty Level)
- Are not eligible for health insurance

To apply, you must complete the following 7 steps:

1. Complete, sign and date the enclosed application
2. Provide a clear copy of your photo ID
   *Please note: Photocopies of all immigration documents including those that are expired MUST be submitted in order to determine eligibility
3. Provide proof of Delaware Residence at time of diagnosis
4. Attach certificate of diagnosis document completed by your treating physician
5. Provide documentation of benefits covered by health insurance to include out of pocket costs before insurance will pay 100% of cancer treatment (if applicable)
6. Attach eligibility status for Health Insurance Marketplace, if uninsured
7. Attach proof of income, such as copies of your federal income tax form, check stubs, award letters, etc. as referenced below. You must indicate the source of income, how often you receive the income and the amount of income of gross income before taxes/deductions. Proof of income must be supplied for all household members.

Current Income to Report

Earnings from Work	Pensions/Retirement/Social Security	Other Income
❖ Wages/Salaries/Tips ❖ Unemployment Compensation ❖ Workers' Compensation ❖ Net Income from self-owned business or farm	❖ Pensions ❖ Retirement Income ❖ Veteran's Payments ❖ Social Security	❖ Disability Benefits ❖ Interest/Dividends ❖ Income from Estates/Trusts/Investments ❖ Net Rental Income ❖ Alimony ❖ Any Other Income

If you need assistance in completing your application or have questions: Please call the DCTP customer service line Monday through Friday from 8:00 a.m. to 4:30 p.m. at **1-844-245-9580 and select option 3.**

PLEASE SEND THE COMPLETED, SIGNED, & DATED APPLICATION IN THE RETURN ENVELOPE.
You will receive written notification of eligibility and the right to appeal.

Revised December 2019

Please complete and sign this form and return it using the self-addressed envelope.
Your eligibility for this program cannot be determined unless your application is signed and all documents requested are attached.

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1. Applicant Information

Application type - Check one:

New _____ Waiver _____

First Name	MI	Last Name	Social Security Number*	Marital Status	Household Size
			- - *Social Security Number is optional, however, providing it will help facilitate processing your application	☐ Married/Civil Union ☐ Divorced ☐ Widowed ☐ Never Married/Civil Union ☐ Separated	

Residence Street Address (cannot be a P.O. Box)	Apt. No.	City	Zip	County	Phone Number
Mailing Address (if different from above)	Apt. No.	City	Zip	County	Phone Number

Ethnicity	Race	Gender	Date of Birth	Do you have Health Insurance?
☐ Hispanic ☐ Non- Hispanic	☐ Alaskan ☐ Hawaiian ☐ White ☐ Pacific Islander ☐ Asian ☐ Other ☐ Black ☐ American Indian ☐ More than one race	☐ Female ☐ Male	/ / MM / DD / YYYY	☐ Yes ☐No If yes: Plan Name: Plan Phone Number:

If you are not a U.S. citizen or a U.S. national, do you have eligible immigration status? ☐ **Yes** ☐ **No**

If yes, please fill in your document type and ID number. _____

*Photocopies of all immigration documents including those that are expired MUST be submitted in order to determine eligibility.

Were you a Delaware resident at the time of your cancer diagnosis? ☐ **Yes** ☐ **No**

What was the date of your cancer diagnosis? _____ / _____ / _____
MM DD YYYY

Do you currently live in Delaware and intend to remain in Delaware? ☐ **Yes** ☐ **No**

Name of Treating Physician: _____ **Phone number:** _____

2. Income Information

Documentation (or Proof) should be provided with this application. Please send photocopies only, not original documents.
You, your spouse's/legal partner's, and other household members' income must be reported. Earnings, interest on savings and/or investments, Social Security, Veteran Benefit, cash given to you and any other income must be reported. If you have no income, please provide written explanation of how you are supported.

Rights and Responsibilities

I have read or have had read to me all of the statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.
I understand that all the information I give is confidential and federal and state laws limit disclosure of information about me.
I understand and agree to give proof of my statements. I understand that the Department of Health and Social Services may contact other persons or organizations to obtain the necessary proof of my eligibility.

Signature of Applicant or Representative Date

If representative, please print name, relationship and phone number

Name: Relationship: Phone:

Delaware Cancer Treatment Program
Certificate of Cancer Diagnosis
Medical Referral

Facility/Clinic: _____

Client Name: _____ DOB: _____

Cancer Diagnosis Code: _____

- Please enter the cancer diagnosis code and include the fourth/fifth digit of specificity. A three digit diagnosis code will not be accepted when a more specific code is available.

- Please enter the cancer treatment start date. Eligibility in the DCTP will begin on the cancer treatment start date. The Delaware Cancer Treatment Program does not cover the cost of services used to diagnose cancer unless those services are considered cancer treatment and are part of the cancer treatment plan. Coverage will not begin until cancer treatment services have been performed.

- The client must need treatment for cancer in the opinion of the applicant's licensed physician of record. Cancer treatment does not include routine monitoring for pre-cancerous conditions or monitoring for recurrence during or after remission.

Diagnosis Date: _____/_____/_____ **Treatment Start Date:** _____/_____/_____

MM DD YYYY MM DD YYYY

_____ _____

Physician Signature Date Physician Printed Name

_____ _____

Physician Phone Number Physician Fax Number

Please send the original certificate with the physician's signature and a completed DCTP Application.
Prescriptions for the treatment of cancer may require a Cancer Diagnosis written on them.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

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