Breast and Cervical Cancer Screening Eligibility Form

Ohio Department of Health

Eligibility-Enrollment Information

Today's Date	Last Name	First Name	Middle Initial	Other Last Names Used

Birth Date	Age Today	Social Security Number

Mailing Address	City	State	Zip	County

Phone Numbers (Is it ok to leave messages regarding eligibility/appointments on these phones? ☐Yes ☐No)

Home Phone number: (_____) _____ Cell Phone number: (_____) _____ E-mail Address _____

Ethnic Background

Are you Hispanic? (Spanish/Hispanic/Latino)

☐Yes ☐No ☐Unknown

Race Which race(s) best describe(s) you?

☐White ☐American Indian or Alaska Native ☐Black or African

☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Other/Unknown

Optional (used for program evaluation only) - check all that apply: ☐Amish ☐Mennonite ☐LGBTQ ☐A woman with a disability

Primary Language: ☐English ☐Spanish ☐ Other_____ Will you need an interpreter at your appointment? ☐Yes ☐No

Healthcare Coverage

Do you have health insurance? ☐Yes ☐No If Yes, name of Insurance Company _____

Do you have Medicaid? ☐Yes ☐No

Do you have Medicare Part B? ☐Yes ☐No

Have you been referred to the Marketplace for health insurance or Expanded Medicaid Plans? ☐Yes ☐No Date Referred _____

Medical Background

Are you having any breast problems? ☐Yes ☐No

Have you ever had a mammogram? ☐Yes ☐No

Date of last mammogram_____

Location of last mammogram_____

Do you have breast implants? ☐Yes ☐No

If yes, which type: ☐Silicone ☐Saline ☐Gel

Do you have a personal history of breast cancer? ☐Yes ☐No

Do you have a known BRCA1 or BRCA2 gene mutation? ☐Yes ☐No ☐Unknown

Do you have any pelvic symptoms? ☐Yes ☐No

Have you ever had cervical cancer? ☐Yes ☐No

Have you ever had a Pap test? ☐Yes ☐No

Date of last Pap test _____

Location of last Pap test _____

Have you had a hysterectomy? ☐Yes ☐No ☐Unknown

If yes, was it due to cervical cancer? ☐Yes ☐No ☐Unknown

If yes, do you still have a cervix? ☐Yes ☐No ☐Unknown

Has your doctor told you that you no longer need pap tests? ☐Yes ☐No

How did you hear about the program? (Check all that apply)

☐ Medical Provider (Name of Provider) _____ ☐ Event (Name of Event) _____

☐ Re-screen/Previously Enrolled ☐BCCP Plastic Business Card ☐ Free Clinic ☐Family/Friend/Word of Mouth

☐ Flyer/Poster/Brochure ☐Newspapers/TV/Radio ☐ Social Media (Facebook, Instragram, etc)

☐ Internet (website, search engine, etc.) ☐Other organization (Komen, community agency, etc.)_____ ☐Other _____

Please continue to the next page.

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Ohio Department of Health

Client Name:

Appointment Information

What is the best time of day for your appointments?_____

Provide the name/phone # of your doctor or clinic _____

If BCCP staff cannot reach you by mail or phone, BCCP staff may contact the following persons for the purpose of obtaining your current address or phone number. Please provide names and telephone numbers of one or two people who can always reach you.

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Are there any circumstances that might prevent you from receiving your cancer screening services?

Please describe those circumstances below, if none, check None

☐ Lack of transportation ☐Time off from work ☐Lack of child care ☐None

☐ Other, please describe: _____

_____

Do you need assistance with any of the following to access medical services? Check all that may apply or check None.

☐ Difficulty with hearing

☐ Difficulty with vision

☐ Difficulty dressing or bathing

☐ Difficulty concentrating, remembering or making decisions

☐ Difficulty with mobility, such as walking or climbing stairs

☐ Difficulty doing errands such as visiting a doctor's office or shopping

☐ Other _____

☐ None

Tobacco Use Cessation OH Quit Line: 1-800-QUIT-NOW

Do you use tobacco? ☐Yes ☐No

☐Yes, I am planning to quit, and agree to have the Quit Line call me. I understand that my participation is voluntary, and that the Ohio Tobacco Quit Line is a free service.

☐Yes, but I do not want a quit line coach to call me.

Please Read and Sign the Informed Consent, Authorization to Disclose Health Care Information and Income Attestation forms.

Office Use Only

State ID _____

☐ 21 or older?

☐ Uninsured/Under-insured?

☐ Within 300% of poverty?

☐ Enroll in BCCP CDC Eligible?

☐ Enroll in BCCP State Eligible?

☐ Enroll in Patient Navigation Services?

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Ohio Breast and Cervical Cancer Project
Self-Attestation of Income

The Ohio Department of Health, Breast and Cervical Cancer Project (BCCP) offers screening and diagnostic services to eligible women in Ohio. Women age 21 years and older with incomes at 300% of the Federal Poverty Level or below, uninsured or insured with co-pays or deductibles, may qualify for paid services through the Ohio BCCP Program. **Re-verification of income is required annually.** The Ohio BCCP Program pays for approved screenings and diagnostic services for Breast and Cervical Cancer; application must be approved by the Ohio BCCP Program prior to service.

Client's Name: _____ DOB: _____ BCCP ID #: _____

Household Size– To determine your household size, include yourself (and if married, your spouse); and, dependent children 18 years or younger.

Circle One: 1 2 3 4 5 6 7 8 9 Other:_____

Family Member Name	Relationship	Age

Total Family Income

Income - Income includes salary and wages, tips, alimony, public assistance, disability, unemployment, Social Security, interest, retirement and pension. Include only income for adults in household.

Name of Person Receiving Income	Employer or Source of Income	Gross Income (before taxes)	Received How Often?
		$	
		$	
		$	
		$	
		$	
		$	

If you report $0 income, please provide a brief explanation of how you are surviving financially:

I hereby attest that the information I have provided the Ohio BCCP Program is true and accurate to the best of my knowledge. I further understand that if the information is demonstrated to be false or inaccurate, I will be removed from the program.

_____ _____

Name (Print) Signature/Date

OHIO DEPARTMENT OF HEALTH BREAST AND CERVICAL CANCER PROJECT (BCCP)
CONSENT FOR CARE AND RELEASE OF PERSONAL INFORMATION

Name:_____ Date of Birth:_____/_____/_____
(Please Print)

1) I understand that the Ohio BCCP Program is a limited screening and diagnostic program for breast and cervical cancer and that only the services authorized by the Ohio BCCP Program (allowable procedures listing) will be covered. I understand that I may be responsible for the cost of additional services and have discussed this with program staff. I have had the opportunity to review the qualifying payable services provided on the back of this consent.

2) I understand that the Ohio BCCP is a payer of last resort. If I have medical insurance, my service will be submitted to my insurance company first. The Ohio BCCP must obtain an explanation of my benefits for those services to determine additional payment by the program. The Ohio BCCP Program will assist in paying the claim up to the Medicare Part B rates for allowable services. I understand that the Ohio BCCP Program may not be able to pay the entire claim.

3) I understand that if I do not qualify for the Ohio BCCP Program due to eligibility guidelines, I qualify for navigation services. I understand that the Ohio BCCP Navigated Only Programs do not cover the cost of medical services; however, through participation, navigators will work with me to find possible funding sources. There is no cost to receiving the navigation services. Notification will be provided to me if I do not qualify for paid services and documented in my BCCP record.

4) I understand that as a part of my health care with the Ohio BCCP, records are created and maintained describing my physical health history, symptoms, examination and test results, diagnosis, treatment, and plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, including communicating among the providers who contribute to my care; means for verification of services for payment; and tool for health care operations, such as assessing quality.

5) I give permission for my health care provider, laboratory, clinic, radiology unit and/or hospital to provide the Ohio BCCP Program results and claims of my breast and cervical cancer screening exams, and/or results, follow-up exams and treatment.

6) I understand that as a condition of receiving care with the Ohio BCCP, Ohio BCCP may use or disclose my health information for treatment, payment and health care operations purposes. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to me, and which I have had the opportunity to review.

7) I release this program and its employees and agents from any claims, demands and actions related to my participation in the Ohio BCCP Program. This includes any claims related to a failure to detect or diagnose cancer and/or failure of treatment, or any act or omissions related to diagnosis or treatment while I am a part of the program.

8) I understand that I have a right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent that Ohio BCCP has acted in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

9) I hereby authorize the Ohio BCCP staff, by my signature below, if they are unable to contact me via mail or telephone, to contact the following person for the purpose of obtaining my current address and/or telephone number:

Name: _____ Phone Number: _____

10) Ohio Tobacco QUIT Line – Patient Fax Referral Form Authorization to Release Information:

☐ Yes, I am planning to quit, and agree to have the Quit Line call me. I understand that my participation is voluntary, and that the Ohio Tobacco Quit Line is a free service.

Signature:_____ Date: _____
(This consent expires 2 years from date signed)

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OHIO DEPARTMENT OF HEALTH BREAST AND CERVICAL CANCER PROJECT (BCCP)
CONSENT FOR CARE AND RELEASE OF PERSONAL INFORMATION

Payable BCCP Services

Cervical Cancer Screening & Diagnostic	
If I am age 21 – 29	• An office visit with a doctor or nurse for Pap test every three (3) years. (Office visit may include pelvic exam and clinical breast exam - CBE) • Follow-up exams and diagnostic testing for abnormal pap test.
If I am age 30+	• An office visit with a doctor or nurse for a Pap test every three (3) years or Pap + HPV test every five (5) years. (Office visit may include pelvic exam and Clinical Breast Exam (CBE) • Follow-up exams and diagnostic testing for abnormal pap test.

Breast Cancer Screening & Diagnostic	
If I am age 21 – 39	• Screening/diagnostic mammography if a doctor determines a need for screening or diagnostic services based on a clinical exam, family history or other factors. (May include office visit for order) • Follow-up office visits/exams and diagnostic testing for abnormal mammogram results.
If I am age 40	• Bi-annual (every two years) screening mammography. (May include office visit for order) • Follow-up office visits/exams and diagnostic testing for abnormal mammogram results.

All services must be approved and scheduled by the Regional Enrollment Agency; **clients are not to schedule their own appointments.** Appointments are made with a contracted BCCP Provider for services to be covered. Pre-authorization or approval is needed for diagnostic testing that is allowed by the current listing of procedure codes.

If I am diagnosed with breast or cervical pre-cancer or cancer, program staff will check my income to help me find the best treatment resources. I may be eligible for BCCP Medicaid. I may be required to prove my identity, that I am a United States citizen or legal alien and provide income tax statements or paycheck stubs to prove my income in order to apply for BCCP Medicaid.

Things Ohio BCCP does not pay for	
Under age 40	• Screening/diagnostic mammograms without physician referral
Any Age	• Any cancer treatment • Yearly Well Woman Visit • Yearly Mammography • Any services unless to screen or diagnose breast or cervical cancer • Other test doctor may order such as blood or urine tests. • Exams I had before signing up for this program • Inpatient hospital or treatment services. • Medication prescribed at office visits.

Regional staff will review all allowable procedures prior to any medical services.