

Breast and Cervical Cancer Screening Eligibility Form



Eligibility Enrollment Information

Today's Date	Legal Last Name	Legal First Name	Middle Initial	Other Last Names Used
Preferred Name	Preferred Pronouns	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: () Email Address: _____

Ethnic Background Are you Hispanic? (Spanish/Hispanic/Latino) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Race Which category best describes your race? (One or more categories may be marked.) <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other race not listed (please specify) _____
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What is your country of birth? _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a mammogram before today? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last mammogram before today _____ or estimated number of years ago: <input type="checkbox"/> Less than 1 <input type="checkbox"/> 1-2 <input type="checkbox"/> 2-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-10 <input type="checkbox"/> 10+ Location of last mammogram before today _____ If yes, were the results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know Do you have breast implants? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which type: <input type="checkbox"/> Silicone <input type="checkbox"/> Saline <input type="checkbox"/> Gel Do you have a personal history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a known BRCA1 or BRCA2 gene mutation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	Do you have any pelvic symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had cervical cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a Pap test before today? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last Pap test before today _____ or estimated number of years ago: <input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-10 <input type="checkbox"/> 10+ Location of last Pap test before today _____ If yes, were the results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know Have you had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know If yes, was it due to cervical cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know Other reason: <input type="checkbox"/> bleeding <input type="checkbox"/> fibroids <input type="checkbox"/> endometriosis <input type="checkbox"/> I don't know <input type="checkbox"/> other _____ If yes, do you still have a cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know Has your doctor told you that you no longer need Pap tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please continue to the next page.



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Client Name: _____

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

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 mobility, such as walking or climbing stairs
- Difficulty with vision Difficulty doing errands such as visiting a doctor's office or shopping
- Difficulty dressing or bathing Other _____
- Difficulty concentrating, remembering or making decisions None

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

Do you use tobacco? Yes No

- Yes, I am planning to quit, and agree to have the Ohio Tobacco 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 an Ohio Tobacco Quit Line coach to call me.



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

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: _____
(Please Print)

Date of Birth: _____/_____/_____

- 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)

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	<ul style="list-style-type: none"> • 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+	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Screening/diagnostic mammograms without physician referral
Any Age	<ul style="list-style-type: none"> • 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.