

BREAST AND CERVICAL CANCER SCREENING ELIGIBILITY FORM

What is your age?	What is your family's yearly income before taxes?	Number of people in household?	
Last Name	First Name	Middle Initial	Other last names used?
Mailing Address	City	State	Zip
Birth Date	Social Security Number	Email	County
Home Phone (xxx) xxx-xxxx	Cell phone (xxx) xxx-xxxx	Messages regarding eligibility/appointments ok at these numbers?	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Ethnic Background			
Are you Hispanic? (Spanish/Hispanic/Latino)		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
Race: What race best describes you?		<input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other/unknown	
Healthcare Coverage			
Do you have Medicare Part B?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you have Medicaid?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you have health insurance?		<input type="checkbox"/> YES <input type="checkbox"/> NO Name:	
How much is the deductible? \$0.00			
Have you been referred to the Marketplace for health insurance or Expanded Medicaid Plans?			
<input type="checkbox"/> YES <input type="checkbox"/> NO		Referral Date MM / DD / YYYY	
Medical Background			
Are you having breast problems?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Date of last mammogram?		<input type="checkbox"/> MM / DD / YYYY <input type="checkbox"/> Never had a mammogram	
Do you have breast implants?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
History of breast cancer? (personal/family)		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
Date of last Pap test?		<input type="checkbox"/> MM / DD / YYYY <input type="checkbox"/> Never had a Pap test	
Hysterectomy?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
If yes, due to cervical cancer?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
If yes, do you still have a cervix?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
Tobacco Use Cessation			
		MT QUIT Line: 1-800-QUIT-NOW	
Do you use tobacco?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> I am ready to quit & ask that a quit line coach call me, I understand that the MT Quit Line will inform my provider about my participation <small>Please sign the Montana Tobacco Quit Line Patient Fax Referral Form Authorization to Release Information section on the Informed Consent and Authorization to Disclose Health Care Information page.</small>			
<input type="checkbox"/> I do not want a Quit Line coach to call me			
How did you hear about the program?			
<input type="checkbox"/> Medical Provider Name:			
<input type="checkbox"/> Internet <input type="checkbox"/> Pink/Purple Card (Pamphlets)		<input type="checkbox"/> TV <input type="checkbox"/> Re-screen/Previously enrolled	
<input type="checkbox"/> Family/Friend/Word of Mouth <input type="checkbox"/> Presentation		<input type="checkbox"/> MAIWHC <input type="checkbox"/> Fair - Job/Health or Pow Wow	
<input type="checkbox"/> Special Promotion/Promo Ad <input type="checkbox"/> Newspapers/Newsletters		<input type="checkbox"/> Government Office <input type="checkbox"/> Radio	
<input type="checkbox"/> Other:			

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How can we help?

Our mission is to improve and protect the health of Montanans by creating conditions for healthy living

What health areas would like assistance with?

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 of work
 None

Other, please describe:

Do you need assistance with any of the following to access medical services? Check all that apply

Difficulty with hearing
 Difficulty with vision
 Difficulty dressing or bathing
 Difficulty with concentration, 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
 None

What resources are you or your family interested in learning more about from the following topics?

<input type="checkbox"/> Arthritis Exercise Programs	<input type="checkbox"/> Self	<input type="checkbox"/> Family
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Self	<input type="checkbox"/> Family
<input type="checkbox"/> Asthma	<input type="checkbox"/> Self	<input type="checkbox"/> Family
<input type="checkbox"/> Injury Prevention	<input type="checkbox"/> Self	<input type="checkbox"/> Family
<input type="checkbox"/> Cardiovascular Health	<input type="checkbox"/> Self	<input type="checkbox"/> Family
<input type="checkbox"/> Nutrition and Physical Activity	<input type="checkbox"/> Self	<input type="checkbox"/> Family
<input type="checkbox"/> Chronic Disease Self-Management Program: Living Life Well	<input type="checkbox"/> Self	<input type="checkbox"/> Family
<input type="checkbox"/> None, not interested	<input type="checkbox"/> Self	<input type="checkbox"/> Family

Please Read and Sign the Informed Consent and Authorization to Disclose Health Care Information on the next page

Office Use Only

State ID

Eligibility Determined by: _____ Date: _____ MM / DD / YYYY

Prior approval given by: _____ Date: _____ MM / DD / YYYY

**BREAST AND CERVICAL
CANCER SCREENING
ELIGIBILITY FORM**

Please Read and Sign

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Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Centers for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana women can be screened through this program for breast and cervical cancers. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered

The MCCP only provides services for breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

Insurance Information

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), the laboratory reading my Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask questions about the MCCP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out of the MCCP at any time.

Montana Tobacco QUIT Line - Patient Fax Referral Form Authorization To Release Information

Yes, I am ready to quit & ask that a quit line coach call me. I understand that the Montana Tobacco Quit Line will inform my provider about my participation.

Client Signature:

Client Signature:	Print Full Name:
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Date:
