BREAST AND CERCIVAL 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? ❑ YES ❑ NO

Ethnic Background

Are you Hispanic? (Spanish/Hispanic/Latino) ❑ YES ❑ NO ❑ Unknown

Race: What race best describes you?

❑ White ❑ American Indian/Alaska Native ❑ Black/African American ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ Other/unknown

Healthcare Coverage

Do you have Medicare Part B? ❑ YES ❑ NO

Do you have Medicaid? ❑ YES ❑ NO

Do you have health insurance? ❑ YES ❑ NO Name:

How much is the deductible? $0.00

Have you been referred to the Marketplace for health insurance or Expanded Medicaid Plans?

❑ YES ❑ NO Referral Date MM / DD / YYYY

Medical Background

Are you having breast problems? ❑ YES ❑ NO

Date of last mammogram? MM / DD / YYYY ❑ Never had a mammogram

Do you have breast implants? ❑ YES ❑ NO

History of breast cancer? (personal/family) ❑ YES ❑ NO ❑ Unknown

Date of last Pap test? MM / DD / YYYY ❑ Never had a Pap test

Hysterectomy? ❑ YES ❑ NO ❑ Unknown

If yes, due to cervical cancer? ❑ YES ❑ NO ❑ Unknown

If yes, do you still have a cervix? ❑ YES ❑ NO ❑ Unknown

Tobacco Use Cessation **MT QUIT Line: 1-800-QUIT-NOW**

Do you use tobacco? ❑ YES ❑ NO

❑ 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

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.

❑ I do not want a Quit Line coach to call me

How did you hear about the program?

❑ Medical Provider Name:

❑ Internet ❑ Pink/Purple Card (Pamphlets) ❑ TV ❑ Re-screen/Previously enrolled

❑ Family/Friend/Word of Mouth ❑ Presentation ❑ MAIWHC ❑ Fair - Job/Health or Pow Wow

❑ Special Promotion/Promo Ad ❑ Newspapers/Newsletters ❑ Government Office ❑ Radio

❑ Other:

BREAST AND CERVICAL CANCER SCREENING ELIGIBILITY FORM

Last Name	First Name	Middle Initial	Other last names used?

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?

❑ Arthritis Exercise Programs	❑ Self	❑ Family
❑ Diabetes	❑ Self	❑ Family
❑ Asthma	❑ Self	❑ Family
❑ Injury Prevention	❑ Self	❑ Family
❑ Cardiovascular Health	❑ Self	❑ Family
❑ Nutrition and Physical Activity	❑ Self	❑ Family
❑ Chronic Disease Self-Management Program: Living Life Well	❑ Self	❑ Family
❑ None, not interested	❑ Self	❑ 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

Last Name	First Name	Middle Initial	Other last names used?

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 breast and cervical cancer screening services for age and income eligible women. Each time a woman is screened for breast cancer, she may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a woman 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:

Date: