MCCP Breast and Cervical Cancer Screening Enrollment Form

Eligibility-Enrollment Information

What is your age?	Family's yearly income before taxes?	Number of people in household?

Last Name	First Name	Middle Initial	Other Last Names Used

Birth Date	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 Check all races that apply.

☐ White ☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown

Healthcare Coverage

Do you have Medicare Part B? ☐Yes ☐No Do you have Medicaid? ☐Yes ☐No Do you have health insurance? ☐Yes ☐No

If Yes, name of Insurance Company _____ What is the deductible amount? _____

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 _____/_____/_____

Do you have breast implants? ☐Yes ☐No

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

Have you had a Pap test? ☐ Yes ☐ No

Date 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

Do you use tobacco? ☐ Yes ☐ No **Tobacco Use Cessation** **MT Quit Line: 1-800-QUIT-NOW**

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 ☐ None

☐ Other, please describe: _____

_____

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

☐ Medical Provider (Name of Provider) _____

☐ Internet ☐ Pamphlets/Flyers ☐ TV ☐ Re-screen/Previously Enrolled ☐ Family/Friend/Word of Mouth

☐ Presentation ☐ MAIWHC ☐ Fair-Job/Health or Pow Wow ☐ Special Promotion/Promotional Ad ☐ Newpapers/Newletters

☐ Government Office ☐ Radio ☐ Other _____

Please Read and Sign the Informed Consent and Authorization to Disclose Health Care Information.

PublicHealth MTTHE 406 MONTANA CANCER CONTROL PROGRAMS	**Please Read and Sign**	MONTANA DPHHS

Client Name: , _____

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Center 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, she may receive a Pap test and/or an HPV test. If any of the initial tests for breast and cervical 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. I understand if I have Medicare Part B or Medicaid, I am not eligible for financial assistance.

Insurance Information

I understand if I do meet the eligibility requirements for the MCCP and have insurance coverage, other than Medicare Part B or Medicaid, I still may be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed up to the maximum allowable Medicare reimbursement rate 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), and/or 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.

Client Signature: _____ Date: ____/____/____

Print Full Name: _____