Program Application

EFFECTIVE: 7/1/2018

Appointment
Date/Time: ________/________

Type of Appointment
(Circle only one): **Screening or Diagnostic**

Section 1: Applicants Information

SCREENING STATUS: __ INITIAL __ RESCREEN __ SHORT INTERVAL FOLLOW-UP (or REPEAT exam)

NAME (Legal or as it appears on Social Security Card): REQUIRED

Last Name First Name M.I.

DATE OF BIRTH: (MM/DD/YYYY)
/ /

SOCIAL SECURITY NO.
- -

DATE OF BIRTH & SOCIAL SECURITY NUMBER REQUIRED

STREET ADDRESS (REQUIRED):

ADDRESS:____

CITY & ZIP CODE:_____________________________________

PRIMARY PHONE NO. : ☐ **HOME** ☐ **WORK** ☐ **CELL**

( )________ - ______________

ALTERNATIVE PHONE: ☐ **HOME** ☐ **WORK** ☐ **CELL**

( )________ - ______________

RESIDENTIAL STATUS
Check all that apply:
REQUIRED

☐ **You must be a Florida Resident to be eligible**

☐ **Underline which applies to you:** US Citizen or under Alien Status

WHAT IS YOUR? REQUIRED

Height ***in inches*:** _______

Weight ***in pounds*:** _______

IS IT OK TO LEAVE A MESSAGE? ☐ Yes ☐ No

BEST TIME TO REACH YOU? ☐ Anytime ☐ AM or ☐ PM

PREFERRED DAY/TIME OF APPOINTMENT?

DAY : ______________ AM OR PM

ARE YOU OF LATINO OR HISPANIC ORIGIN?
REQUIRED

1. ☐ Yes
2. ☐ No

WHAT LANGUAGES DO YOU SPEAK? REQUIRED

Primary Language:

____

Other Language:

____

Do you have a history of Hypertension?

1.☐ Yes 2.☐ No

WHAT RACE OR RACES DO YOU CONSIDER YOURSELF?

(Choose all that Apply) **REQUIRED**

1. ☐ American Indian or Alaska Native
2. ☐ Asian
3. ☐ Black or African American
4. ☐ Native Hawaiian or Other Pacific Islander
5. ☐ White

DO YOU USE TOBACCO PRODUCTS? REQUIRED

1.☐ Daily 2.☐ Some days 3.☐ Not at all

4. ☐ Declined to Answer

If 1 or 2, was referred to Quitline? 1.☐ Yes 2.☐

******Quitline Phone # 1-877-822-6669******

HOW DID YOU LEARN ABOUT THIS PROGRAM? 1. ☐ Local ACS 2. ☐ Brochure 3. ☐ CHD

4. ☐ Community 5. ☐ Family/Friend 6. ☐ Internet 7. ☐ Medical Office 8. ☐ Newspaper

9. ☐ FQHC 10. ☐ Postcard 11. ☐ Outreach 12. ☐ Television 13. ☐ Radio 14. ☐ Social Media

15. ☐ Educational Session 16. ☐ In-reach 17. ☐ Bus wraps/signs 18. ☐ Billboards

DO YOU HAVE BREAST IMPLANTS? 1. ☐ **YES 2.** ☐ **NO PLEASE CHECK ONE**

Section 2: Health History

Breast Exam Background (Check Only One Box For Each Category) **REQUIRED**

Have you ever been diagnosed with BREAST CANCER? ☐ YES ☐ NO

When was your last MAMMOGRAM **before** enrolling in this program?

☐ Last MAMMOGRAM (month_________ /year___________) ☐ NONE ☐ Unsure (5+ years?)

Where was it done? (**PROVIDER**) ____________________________________

Cervical Exam Background (Check Only One Box For Each Category) **REQUIRED**

Have you ever been diagnosed with INVASIVE CERVICAL CANCER? ☐ YES ☐ NO

When was your last PAP SMEAR **before** enrolling in this program?

☐ Last PAP SMEAR exam (month________ /year________) ☐ NONE ☐ Unsure (5+ years?)

HYSTERECTOMY? ☐ **YES** ☐ **NO** (☐ **Partial or** ☐ **Full) When? ________** **REQUIRED**

Are you currently experiencing any problems with breast or cervix? ☐ YES ☐ NO

If so, briefly explain ____

Section 3: Financial Eligibility REQUIRED

Do you have Medicaid? ☐ **YES** ☐ **NO** **Do you have Medicare?** ☐ **YES** ☐ **NO**

Do you have any form of health insurance? ☐ **YES** ☐ **NO**

Number of people in your Household. ______ (Please include yourself, spouse or civil union partner, and dependent children)

Net Household Income : **REQUIRED** **$ _________ Month or $ ________ Year**

Circle Family Size	2018 DOH Scale Monthly Income	2018 DOH Scale Yearly Income
1	$2,023	$24,280
2	$2,743	$32,920
3	$3,463	$41,560
4	$4,183	$50,200
5	$4,878	$58,840
6	$5,623	$67,480
7	$6,343	$76,120
8	$7,038	$84,460
9	$7,783	$93,400
10	$8,503	$102,040

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:
If you obtain health insurance coverage, while under the BCCEDP, it is your responsibility to notify the BCCEDP program office as soon as possible.

_______________________________________ REQUIRED ___

(Signature/Date)

If you have any questions, please call (800) 226-6110 between 8:00 a.m. and 5:00 p.m., Monday through Friday. In the event of reaching voicemail, please leave a detailed message. We will make every effort to return your call in a timely manner.

FOR PROGRAM OFFICE USE ONLY:

THIS APPLICATION HAS BEEN: ☐ *APPROVED* ☐ *DENIED*

EFFECTIVE: __________________________ (MM/DD/YYYY)

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: ______________________________ **Phone #:** ______________

Address: ______________________________ **Fax #:** ______________

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: ______________________________ **Phone #:** ______________

Address: ______________________________ **Fax#:**______________

INFORMATION TO BE DISCLOSED: (**Initial Selection**)

_____ General Medical Record(s), including STD and TB X_____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records X_____ Consultations

X_____ Diagnostic Test Reports (Specify Type of test(s)) ______________________________

X_____ Other: (specify) ______________________________

I specifically authorize release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

X_____ Continuity of Care _____ Personal Use X_____ Other (specify)__Provider Reimbursement & Care Coordination

EXPIRATION DATE: This authorization will expire (insert date or event) **one year from signature date**. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

x______________________________ x______________________________
Client/Representative Signature Date

x______________________________ ______________________________
Printed Name Representative's Relationship to Client

x______________________________ ______________________________
Witness (optional) Date

Client Name:______________________________

SS#: ______________________________

DOB: ______________________________

DH 3203, 11/08 **Original:** To File **Copy:** To Client **Copy:** To Accompany Disclosure

Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

- I agree to become a client of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP).
- Florida is my primary residence.
- I declare that my net family annual income is at or below 200% of the Federal poverty guideline and I have no health insurance that pays for breast and cervical cancer screening exams.
- ****I understand that I may have a share of cost for some services.**
- I agree to use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test) and I agree to complete any follow-up tests within 60 days.
- I understand that the FBCCEDP is a breast and cervical cancer **screening** program, not a cancer **treatment** program. If I am diagnosed with breast or cervical cancer as a result of my FBCCEDP screening, I will be referred to a provider for my cancer treatment.
- I agree to allow an exchange and release of information via fax or mail between my health care providers, the Florida Department of Health Breast and Cervical Cancer Early Detection Program, the Florida Department of Health Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination results, and any follow up tests and treatments done as a result of the examination, even if the tests or treatment I receive are not paid for by the FBCCEDP.
- I agree to receive phone or mail contact from FBCCEDP staff about my health care.
- I understand this agreement is good for one year unless my program eligibility changes.
- I understand that taking part in this program is my choice and I may withdraw from the program at any time.

______________________________ ______________

Client signature Date

____

Printed name

____

Date of birth

Revised 7/1/18