DO NOT EMAIL - PLEASE RETURN COMPLETED APPLICATION BY MAIL OR FAX
FAX: (386) 274-0609
MAIL TO: FLORIDA HEALTH, BIN #119,
1845 HOLSONBACK AVE, DAYTONA BEACH 32117

Appointment
Date/Time: _____/_____
Type of Appointment
(Circle only one): **Screening or Diagnostic**

Program Application
EFFECTIVE: 7/1/2015

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)
( )_____ - _____

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

RESIDENTIAL STATUS
Check all that apply:
REQUIRED
☐ Florida Resident
☐ US Citizen or Resident or Alien Status

WHAT IS YOUR? REQUIRED
Height *in inches*: _____
Weight *in pounds*: _____

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 a smoking cessation program referral offered to you? 1.☐ Yes 2.☐ No
Referred to Quitline? 1.☐ Yes 2.☐

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

HOW DID YOU LEARN ABOUT THIS PROGRAM?

REACH AND CONNECT

1.☐ Local ACS 2.☐ Brochure 3.☐ CHD 4.☐ Community 5.☐ Family/Friend
6.☐ Internet 7.☐ Medical Office 8.☐ Newspaper 9.☐ FQHC 10.☐ Postcard

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)

Gross Household Income (before Taxes): **REQUIRED** $ _____ Month or $ _____ Year

Circle Family Size	2015 DOH Scale Monthly Income	2016 DOH Scale Yearly Income
1	$1,962.00	$23,540
2	$2,655.00	$31,860
3	$3,348.00	$40,180
4	$4,042.00	$48,500
5	$4,735.00	$56,820
6	$5,428.00	$65,140
7	$6,122.00	$73,460
8	$6,815.00	$80,780
9	$7,358.00	$88,300
10	$8,052.00	$96,620

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 "Suzy or Marisol" at **(800) 226-6110** between 8:00 a.m. and 5:00 p.m., Monday through Friday. In the event of reaching voice mail, 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 redisclosed 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 _____ Client/Representative Signature

x _____ Date

x _____ Printed Name

_____ Representative's Relationship to Client

x _____ Witness (optional)

_____ Date

Client Name: _____

SS#: _____

DOB: _____

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 7/1/15

Florida HEALTH
Volusia County

INITIATION OF SERVICES
GENERAL RELEASE AND ACKNOWLEDGEMENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

PART I CONSENT TO RELEASE AND RECEIVE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

Client Name: _____

Name of Agency: FL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM / VOLUSIA COUNTY HEALTH DEPARTMENT

Agency Address: 1845 HOLSONBACK DRIVE, DAYTONA BEACH, FLl 32117

I, consent to the use and disclosure (including via fax) of Protected Health Information for treatment, payment or health care operations. This includes specific consent to fax or receive any of the following information listed below via fax:

Medical	Sexually transmitted diseases	Alcohol/drug abuse	HIV/AIDS
Tuberculosis	Case management information	Psychiatric/ Psychology	

PART II MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST
(Only applies to Medicare Clients)

As Client/ Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release Protected Health Information to the Social Security Administration or its intermediaries / carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART III ASSIGNMENT OF BENEFITS (only applies to Third Party Payers)

As Client /Representative signed below, I, assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART IV BY MY SIGNATURE BELOW I VERIFY THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ _____ _____
***Client/Representative Signature Self or Representative's Relationship to Client ***Date

_____ _____
Witness Date

PART V WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____(Date).

_____ _____ _____
Client/Representative Signature Self or Representative's Relationship to Client Date

_____ _____
Witness Date

Client Name: _____
Soc. Sec. #: _____
DOB: _____

Original: To File **Copy:** To Client

DH 3204, 12/03 Stock Number:

State of Florida
Department of Health

Florida HEALTH
Volusia County

Notice of Privacy Practices Acknowledgment Form

Name: _____ **Client ID#** _____

Facility/Site/Program: _____

I have received a copy of the DOH Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: _____ **Date:** _____
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____
(Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
date

___ Face to face meeting
___ Mailing
___ Email
___ Other _____

Reason Individual or Representative did not sign this form:
___ Individual or Representative chose not to sign
___ Individual or Representative did not respond after more than **one** attempt
___ Email receipt verification
___ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.
___ Face to face presentation(s) _____
___ Telephone contact(s) _____
___ Mailing(s) _____
___ Email _____
___ Other _____

Staff Signature: _____ **Title:** _____

Print Name: _____

Date: _____

This form must be retained for a period of at least six years in the appropriate record.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction. However, in situations where you or someone on your behalf pays for an item or service in full, and you request information concerning said item or service not be disclosed to an insurer, the Department will agree to the requested restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).
HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

Affordable Care Act and the Federally Facilitated Marketplace

Websites and Telephone Numbers

- For questions about the Affordable Care Act visit the Marketplace at: www.healthcare.gov

- Or call: **1-800-318-2596**, 24 hours, 7 days a week. Deaf and Hard of Hearing TTY/TDD technology: 1-855-889-4325

- For help enrolling in the marketplace or for additional help from people or organizations close to where you live, go to: https://www.healthcare.gov/how-do-i-get-help-enrolling-in-the-marketplace/

  or

  https://localhelp.healthcare.gov/

- For a Guide to the Affordable Care Act and Information about Health Insurance Reform go to: http://www.myfloridacfo.com/division/consumers/HealthReform.htm

- If you have questions or concerns about licensed insurers in the state of Florida, please contact the Division of Consumer services Helpline at 1-877-693-5236 or visit: http://www.myfloridacfo.com/Division/Consumers/PurchasingInsurance/VerifyBeforeYouBuy.htm