



# Program Application

EFFECTIVE: 3/15/2020

## 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**

DATE OF BIRTH: (MM/DD/YYYY)

SOCIAL SECURITY NO.

Last Name First Name M.I.

**DATE OF BIRTH & SOCIAL SECURITY NUMBER REQUIRED**

**STREET ADDRESS (REQUIRED):**

PRIMARY PHONE NO. :  HOME  WORK  CELL

ADDRESS: \_\_\_\_\_

( ) \_\_\_\_\_ - \_\_\_\_\_

CITY & ZIP CODE: \_\_\_\_\_

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

**Do you have a history of Diabetes or Pre-Diabetes?**

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.  No

**\*\*\*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	2020 DOH Scale Monthly Income	2020 DOH Scale Yearly Income
1	\$2,127	\$25,520
2	\$2,873	\$34,480
3	\$3,620	\$43,440
4	\$4,367	\$52,400
5	\$5,113	\$61,360
6	\$5,860	\$70,320
7	\$6,607	\$79,280
8	\$7,353	\$88,240
9	\$8,100	\$97,200
10	\$8,847	\$106,106

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
- Progress Notes
- History and Physical Results
- Immunizations
- Family Planning
- Prenatal Records
- Consultations
- Diagnostic Test Reports (Specify Type of test(s)) \_\_\_\_\_
- 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:

- Continuity of Care
- Personal Use
- 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.

**REDISCLASURE:** 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.

**REVOCAATION:** 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.

\_\_\_\_\_  
 Client/Representative Signature

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Witness (optional)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Representative's Relationship to Client

\_\_\_\_\_  
 Date

**Client Name:** \_\_\_\_\_

**SS#:** \_\_\_\_\_

**DOB:** \_\_\_\_\_



**Florida Breast and Cervical Cancer Early Detection Program  
Annual Applicant Agreement**

Please read each statement and sign at the bottom of the page.

I declare that:

1. I want to become a client of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) and I may withdraw at any time.
  2. My net family annual income is at or below 200% of the Federal Poverty Level and I have no health insurance that pays for breast and cervical cancer screening exams.
  3. I will no longer be eligible for FBCCEDP if my income changes to above 200% of the Federal Poverty Level.
  4. I will call FBCCEDP once I enroll into health insurance and give them the name of the health insurance company, policy number and effective date. If my health insurance covers breast and cervical cancer screenings my screenings will no longer be paid for by FBCCP.
  5. I will disclose any breast or cervical screening services that may impact my eligibility enrollment in FBCCEDP.
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6. I may have a share of cost for some services.
  7. I will use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test).
  8. I agree to complete any follow-up test within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.
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9. I will allow an exchange and release of my medical information between my health care providers, the FBCCEDP, the Florida Department of Health's Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination and procedure results, even if they were not paid by FBCCEDP.
  10. I agree to receive phone or mail contact from FBCCEDP and the Department of Children and Families (DCF) Medicaid Program about my health care.
  11. I understand that the FBCCEDP is a breast and cervical cancer screening program, not a cancer treatment program.
  12. If I am diagnosed with breast or cervical cancer as a result of FBCCEDP screening, I will be referred to DCF Medicaid Program who will determine if I am eligible for Medicaid to cover treatment cost. I can reapply to FBCCEDP for screenings once treatment is completed.
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13. This agreement is for one year unless my program eligibility changes. If my eligibility status changes or this agreement expires, I may be responsible for services provided during my FBCEEDP ineligible period.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date of birth

Revised June 2019