Montana Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

Breast and Cervical Cancer Screening Eligibility Form

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

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 Which race(s) best describe(s) you?
☐ White ☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other 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 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 ever 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

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

Do you use tobacco? ☐ Yes ☐ No

☐ Yes, and I'm ready to quit and ask that a quit line coach call me. I understand that the MT Quit Line will inform my provider about my participation. If yes, 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.

☐ Yes, but I do not want a quit line coach to call me..

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

☐ Medical Provider (Name of Provider) _____
☐ 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/ Promotional Ad ☐ Newspapers/Newsletters
☐ Government Office ☐ Radio ☐ Other _____

Please continue to the next page.

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Client Name: _____

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 you 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 from work ☐ None

☐ Other, please describe: _____

_____

_____

Do you need assistance with any of the following to access medical services? Check all that may apply or check None.

☐ Difficulty with hearing ☐ Difficulty with vision

☐ Difficulty dressing or bathing

☐ Difficulty concentrating, 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

☐ Other _____

☐ None

We have resources and information available about the following topics, what are you or your family interested in learning more about? ☐ self ☐ family

☐ Arthritis Exercise Programs

☐ Diabetes ☐ Asthma ☐ Injury Prevention

☐ Cardiovascular Health

☐ Nutrition & Physical Activity

☐ Chronic Disease Self-management Program: Living Life Well

☐ None, not interested.

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

Office Use Only **State ID** _____

Eligibility Determined by: _____ Date: _____

Prior approval given by: _____ Date: _____

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Please Read and Sign

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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 cancer screening for age and income eligible Montana residents. Montana women can be screened through this program for breast and cervical cancers. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap 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.

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 and 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: _____ **Date:** _____
MM / DD / YYYY

Print Full Name: _____