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 ________ MM ________ DD ________ YYYY

Social Security Number ____________________________

Mailing Address ____________________________  City ____________________________  State ____________________________  Zip ________  County ________

Date of last Pap test ________ MM ________ DD ________ YYYY

Date of last mammogram ________ MM ________ DD ________ YYYY

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 ________

Are you having any breast problems? ________  Yes ________  No ________

Do you have breast implants? ________  Yes ________  No ________

How did you hear about the program? ________

Medical 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 ________

Have you ever had a mammogram? ________  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 ________ MM ________ DD ________ YYYY ________

Are you Hispanic? ________  Yes ________  No ________  Unknown ________

Medical Background

Are you having any breast problems? ________  Yes ________  No ________

Have you ever had a mammogram? ________  Yes ________  No ________

Date of last mammogram ________ MM ________ DD ________ YYYY

Have you had a Pap test? ________  Yes ________  No ________

Date of last Pap test ________ MM ________ DD ________ YYYY

Do you have breast implants? ________  Yes ________  No ________

Do you have a personal or family history of breast cancer? ________

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 ________  Newspapers/Newletters ________

Government Office ________  Radio ________  Other ____________________________

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