Florida HEALTH
Leon

Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

APPLICATION PACKET

Client and Website Only

For questions please call:	
Regional Coordinator:	Natasha Monique Coleman
Counties Served by Region:	Jefferson, Leon, Madison, Taylor, and Wakulla
Phone: 850-404-6404	Confidential Fax: 850-412-2205

Please use checklist below to ensure all paperwork is completed and returned with this coversheet to:

Leon Regional FBCCEDP Office via confidential fax or mail to:

Florida Department of Health Leon County
Florida Breast and Cervical Cancer Early Detection Program
1515 Old Bainbridge Road
Tallahassee, Florida 32304

CLIENT CHECKLIST	
☐	Annual Applicant Agreement
☐	Financial Eligibility Form
☐	Client Enrollment Form
☐	Initiation of Services *(for County Health Departments only)*
☐	Authorization to Disclose Confidential Information
☐	Your Provider's Mammogram Order

Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

The Annual Applicant Agreement (AAA) is used to obtain authorization and information from eligible women enrolled in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). The FBCCEDP will collect participant Protected Health Information (PHI) and Personally Identifiable Information (PII) that is required to provide patient services.

Please read each statement below and agree by signing at the bottom of the document.

As an FBCCEDP applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCCEDP, and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level (FPL) 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 FPL.
4. I will call FBCCEDP Once I obtain 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 FBCCEDP.
5. I will disclose any breast or cervical screening services that may impact my eligibility of enrollment in FBCCEDP.
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 tests within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.**
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 home phone, cellphone, email or postal 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 which will determine if I am eligible for Medicaid benefits to cover treatment cost. I can reapply to FBCCEDP for screenings once treatment is completed.
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 FBCCEDP ineligible period.
14. **As authorized by federal law, Title 5 U.S. Code section 552a, collection of social security numbers by the Florida Department of Health for the FBCCEDP may be necessary in order to apply for and receive Medicaid benefits.**

If you have any questions, contact your Regional Coordinator at the local Regional FBCCEDP office:

Local Regional FBCCEDP: _____ Phone #: _____

_____ _____

Client Signature Date

_____ _____

Printed Name Date of Birth

Client Email Address: _____

Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

FINANCIAL ELIGIBILITY

Client Name: _____ **Date of Birth:** _____ **ID#**_____

1. Do you have Medicaid? ☐ YES ☐ NO **OR** Do you have Medicare? ☐ YES ☐ NO
2. Do you have any form of health insurance? ☐ YES ☐ NO Name of insurance _____
3. **Number of people in your Household.** _____ (include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes): $**_____ Month **OR** **$**_____ Year

Family Size	2021 DOH Scale Monthly Income	2021 DOH Scale Yearly Income
1	$2,146.58	$25,759.00
2	$2,903.25	$34,839.00
3	$3,659.91	$43,919.00
4	$4,416.58	$52,999.00
5	$5,173.25	$62,079.00
6	$5,929.91	$71,159.00
7	$6,686.58	$80,239.00
8	$7,443.25	$89,319.00
9	$8,199.91	$98,399.00
10	$8,956.58	$107,479.00

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 I obtain health insurance coverage, while under the FBCCEDP, it is my responsibility to notify the REGIONAL FBCCEDP office as soon as possible.

Signature _____

Date _____

If you have any questions Please call the regional coordinator at _____ between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.

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Florida Breast and Cervical Cancer Early Detection Program

Client Enrollment Form

LAST NAME:		FIRST NAME:		MAIDEN NAME:		DATE OF BIRTH:	

1. APPLICANT INFORMATION (Please complete each section of this application.)

CONTACT INFORMATION

STREET ADDRESS:	
STREET ADDRESS:	
CITY & ZIP CODE:	
EMAIL ADDRESS:	
PRIMARY PHONE:	
ALTERNATE PHONE:	

BEST TIME TO REACH YOU:

☐ A.M. ☐ P.M. ☐ Anytime

☐ Is it okay to leave a message?

PREFERRED APPT. DAY/TIME:

HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)

☐ American Cancer Society
☐ Brochure
☐ County Health Department
☐ Community/Health Fair event
☐ Family/Friend
☐ Internet/Website
☐ Private Medical Office
☐ Newspaper
☐ Federally Qualified Health Center
☐ Other
☐ Postcard
☐ Television
☐ Radio
☐ Social Media
☐ Educational Session
☐ Bus wraps/benches/signs
☐ Billboards

Name of Community Health Clinic: _____

SCREENING STATUS (Check only one response.)

☐ Initial (first time in program) ☐ Rescreen (previously in program)

☐ Short-term interval follow-up or repeat exam (less than 300 days from last screening)

Do you have health insurance? ☐ Yes ☐ No

If yes, what is the name of your insurance? _____

DEMOGRAPHIC INFORMATION

RESIDENTIAL AND CITIZENSHIP STATUS (Check all that apply.)

☐ Florida resident ☐ U.S. Citizen ☐ Citizen in lawful status ☐ Other

ETHNICITY AND RACE IDENTIFICATION (Check all that apply.)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

RACIAL IDENTITY

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

SPOKEN LANGUAGE(S)

Primary language spoken:	
Additional language(s) spoken:	

Language preference to receive mail:

☐ English
☐ Spanish
☐ Creole

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:

Florida Health Leon

Florida Breast and Cervical Cancer Early Detection Program

Client Enrollment Form

LAST NAME:		FIRST NAME:		MAIDEN NAME:		DATE OF BIRTH:	

2. HEALTH HISTORY

GENERAL HEALTH STATUS (Check all that apply.)

- ☐ Diabetes
- ☐ Pre-Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol

HEIGHT (in.): ☐ WEIGHT (lbs.): ☐

TOBACCO USE (includes vaping, e-cigarettes, and similar products) (Check all that apply.)

- ☐ Daily
- ☐ Some days
- ☐ Never/not at all
- ☐ Declined to answer
- ☐ Were you given a referral to Quitline?
- ☐ Declined referral
- ☐ I am interested in quitting.

BREAST EXAM BACKGROUND (Check all that apply)

- ☐ Do you have breast implants?
- ☐ Are you currently experiencing any issues with your breasts? Explain.

☐ Have you ever been diagnosed with breast cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last mammogram before enrolling in this program? (Month/Year)

☐ None ☐ Unsure (5+ years)

Where was your last mammogram done? (Provider, City, State)

CERVICAL EXAM BACKGROUND (Check all that apply)

- ☐ Are you currently experiencing any issues with your cervix? Explain.

☐ Have you ever been told by a doctor you have invasive cervical cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last Pap test before enrolling in this program? (Month/Year)

☐ None ☐ Unsure (5+ years)

Where was your last Pap test done? (Provider, City, State)

☐ Have you ever had a hysterectomy? Specify whether partial or full.

- ☐ Partial hysterectomy (I still have a cervix)
- ☐ Full hysterectomy (no cervix)

What was the reason for the hysterectomy?

FAMILY HISTORY

Has anyone in your family, such as your mother, sister, brother, or father, been diagnosed with breast cancer? If yes, which relative?

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:

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Florida Breast and Cervical Cancer Early Detection Program

Clinician Report Form

1. CLIENT INFORMATION (Please complete each section of this form.)

LAST NAME: FIRST NAME: MIDDLE NAME: MAIDEN NAME:

DATE OF SERVICE (mm/dd/yyyy):

DATE OF BIRTH (mm/dd/yyyy):

HEIGHT (in.): WEIGHT (lbs.):

MAMMOGRAM STATUS (For office use only)

- ☐ INITIAL
- ☐ RESCREEN
- ☐ SHORT-TERM FOLLOW-UP OR REPEAT EXAM

2. HEALTH HISTORY ASSESSMENT

PRESENT CONDITIONS (Check all that apply)

- ☐ Diabetes
- ☐ Pre-Diabetese
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Client referred to services

TOBACCO USE
(Includes vaping, e-cigarettes and similar products) (Check all that apply)

- ☐ Daily
- ☐ Some days
- ☐ Never/not at all
- ☐ Declined to answer
- ☐ Referred to Quitline
- ☐ No, not referred to Quitline
- ☐ Declined referral

BREAST HEALTH (Check all that apply)

- ☐ Did client report any breast symptoms? (If so, describe below)
- ☐ Client is high risk for breast cancer
- ☐ Risk not assessed
- ☐ Clinical Breast Exam (CBE) completed

DIAGNOSTIC MAMMOGRAM (Check all required conditions that apply)

- ☐ Cystic or solid mass
- ☐ Bloody or serious nipple discharge
- ☐ Nipple or areola scaliness
- ☐ Skin dimpling or retraction
- ☐ Other suspicious findings (please specify):

NOTE: This section requires follow-up of two negatives.

SCREENING MAMMOGRAM
(Please check one CBE result for a screening mammogram)

- ☐ Normal/benign
- ☐ Nodularity
- ☐ Fibrocystic changes

CERVICAL HEALTH (Check all that apply)

(**Note**: FBCCEDP may cover Pap tests every 3-5 years unless previous Pap was abnormal.)

- ☐ Client is high risk for cervical cancer
- ☐ Risk not assessed
- ☐ PAP test performed
- ☐ HPV test performed
- ☐ Pelvic exam performed

If findings were abnormal, comment below.

CLINICIAN NAME: SIGNATURE:

FOR OFFICE USE ONLY
Client Assigned ID# or Pseudo SS#:

Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)
REFERRAL FORM

Breast Diagnostics

		APPT. DATE: _____	**TIME:** _____
Client Name: _____	Date of Birth (MM/DD/YYYY): _____	FBCCEDP Client/Pseudo ID#: _____	FBCCEDP Voucher #: _____
Phone Number: _____	Mailing Address (City, State, and ZIP): _____		
Referred To: _____		Phone Number: _____	
Address: _____			
Referred By: _____	Title: _____		Phone Number: _____
Agency **FLORIDA DEPARTMENT OF HEALTH** _____ **COUNTY (FBCCEDP)** _____			

Type of Procedures (CPT Codes): *Please check all boxes that apply:*

☐	Ultrasound Guided Biopsy (19083, 19084)
☐	Fine Needle Aspiration Biopsy (76942, 19000, 19001)
☐	Excisional Biopsy (19120, 19125 or 19126)
☐	Stereotactic Biopsy (19081 or 19082)
☐	Other: _____

Clinical Provider Name (Please Print): _____	Signature: _____	Date: _____

Mail claims and Fax copies of results to:	**Fax patient reports to:**	
_____, Regional Coordinator Florida Department of Health – _____ County Florida Breast and Cervical Cancer Early Detection Program _____ _____ _____	Provider Name:	_____
	Phone Number:	_____
	Fax Number:	_____
	Confidential Fax:	_____

NOTE:

- **All other diagnostics must be pre-approved or payment cannot be guaranteed.**
- **An invoice is not considered complete for payment without accompanying results.**
- **Unauthorized CPT codes may not be reimbursed.**
- **FBCCEDP is the payor of last resort.**
- **All claims are due no later than _____ business days from the date of service.**