Florida Breast and Cervical Cancer Early Detection Program

CLIENT INFORMATION PACKET

For questions regarding completion please call:

Aiyanna Fleming, Leon Regional Coordinator
Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

PHONE: (850) 404-6404
or
FAX: (850) 412-2205
Pwogram Florida pou Deteksyon Bonè pou Kansè nan Tete ak Kòl Matris
(Florida Breast and Cervical Cancer Early Detection Program)

Akò Anyèl Kandida

Tanpri, li chak deklarasyon epi siyen anba paj la.

Mwen deklare:

1. Mwen vle vin yon kliyan Pwogram Florida pou Deteksyon Bonè pou Kansè nan Tete ak Kòl Matris (Florida Breast and Cervical Cancer Early Detection Program, FBCCEDP) epi mwen ka soti ladann nenpòt lè.

2. Revni famni mwen avan tout dediksyon egal oswa pi ba ke 200% Nivo Povrete Federal la epi mwen pa gen okenn asirans sante ki peye pou egzamen yo pou depistaj kansè nan tete ak nan kòl matris.


4. M ap rele FBCCEDP apre mwen enskri pou asirans sante epi m ap ba yo non konpayi asirans sante a, nimewo kontra asirans lan ak dat li kòmanse. Si asirans sante mwen garanti depistaj yo pou kansè nan tete ak kansè nan kòl matris, FBCCP p ap peye pou depistaj mwen yo ankò.

5. M ap kominike nenpòt tè oswa sèvis depistaj nan tete ak nan kòl matris ki ka afekte kalifikasyon m pou m enskri nan FBCCEDP.


7. M ap itilize yon founisè swen otorize pou egzamen mwen yo pou depistaj nan tete ak/oswa nan kòl matris (egzamen tete, mamogram, ak/oswa tèes Pap).

8. **Mwen dakò pou mwen fè nenpòt tèès suivi nan 60 jou oplita. Si mwen pa respekt machaswiv sa yo, mwen gendwa responsab tout frè yo ann antye oswa an pati pou tout sèvis yo.**

9. M ap otorize yo fè echanj ak kominiyasyon enfòmasyon medikal mwen yo ant founisè swen sante mwen yo. FBCCEDP a, Rejis Done Kansè Depatman Sante Florid an, Sant pou Kontwòl ak Prevansyon Maladi (Centers for Disease Control and Prevention), ak lòt moun ki gen rapò ak swen sante mwen. Enfòmasyon sa yo ka gen ladan istwa medikal, egzamen ak rezilha pwosedi yo, menm si se pa FBCCEDP ki te peye yo pou yo.

10. Mwen dakò pou mwen resevwa koutfil oswa pou FBCCEDP ak Pwogram Medicaid Depatman Timoun ak Fanmi (Department of Children and Families, DCF) eseye kontakte m konsènan swen sante mwen.

11. Mwen konprann FBCCEDP se yon pwogram **pou detekte** kansè nan tete ak kansè nan kòl matris li ye, li pa yon pwogram trètman pou kansè.

12. Si yo fè yon dyagnostik kansè nan tete oswa kansè nan kòl matris pou mwen nan depistaj FBCCEDP a, y ap refere m nan Pwogram Medicaid DCF ki pral detèmine si mwen kalifye pou Medicaid garanti frè pou trètman an. Mwen ka aplike pou depistaj nan FBCCEDP ankò depi trètman an fin fèt.

13. Akò sa a fèt pou **yon** ane, sof si kalifikasyon mwen chanje pou pwogram lan. Si sityasyon kalifikasyon mwen chanje oswa si akò sa a ap ekspire, mwen gendwa responsab pou sèvis yo bay pandan peryòd mwen pa kalifye pou FBCEEDP a.

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**Siyati kliy an**

**Dat**

**Ekri non an ak lèt detache**

**Dat nesans**

Revize an Jen 2019
The Florida Department of Health invites you to take part in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). If you qualify, you will receive your breast and cervical cancer examinations free. If your test results are not normal, FBCCEDP will work with your providers to help you obtain additional tests if needed.

*There may be some cost to you for some tests if you have abnormal results and need diagnostics or treatment.

Income/Insurance Information /Check if you are receiving any of the following (Please check all that apply):

<table>
<thead>
<tr>
<th>Unemployment Insurance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A ☐ Part B ☐</td>
<td>Do you have Medicaid Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

If you have health insurance

Yes ☐ No ☐

If yes please explain: 

Client Agreement:

- I declare my household income is within the FBCCEDP income guidelines listed below.
- I understand that the FBCCEDP screening services are not 100% accurate and will be available to me at no cost if I qualify.
- I understand that all of my screenings and diagnostic exams or treatment may have a share of cost and must be completed within 45 days or payment for these services can not be guaranteed.
- I have read or had the above read to me. I agree that the information I have provided is correct.
- I certify that the above information is correct to the best of my knowledge and belief at the time it was made. I understand that the provider may verify the statement by a secured telephone, in written form, or by face-to-face contact. If the provider is unable to verify wages paid, the signed self-declaration statement provided by the applicant must be accepted as accurate.

<table>
<thead>
<tr>
<th>Household/Family size:</th>
<th>2019 DOH Scale for Monthly Income</th>
<th>2019 DOH Scale for Yearly Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,873.50 - $2,081.58</td>
<td>$22,482 - $24,979</td>
</tr>
<tr>
<td>2</td>
<td>$2,536.50 - $2,818.25</td>
<td>$30,438 - $33,819</td>
</tr>
<tr>
<td>3</td>
<td>$3,199.50 - $3,554.92</td>
<td>$38,394 - $42,659</td>
</tr>
<tr>
<td>4</td>
<td>$3,862.50 - $4,291.58</td>
<td>$46,350 - $51,499</td>
</tr>
<tr>
<td>5</td>
<td>$4,525.50 - $5,028.25</td>
<td>$54,306 - $60,339</td>
</tr>
<tr>
<td>6</td>
<td>$5,188.50 - $5,764.92</td>
<td>$62,262 - $69,179</td>
</tr>
<tr>
<td>7</td>
<td>$5,851.50 - $6,501.58</td>
<td>$70,218 - $78,019</td>
</tr>
<tr>
<td>8</td>
<td>$6,514.50 - $7,238.25</td>
<td>$78,174 - $86,859</td>
</tr>
<tr>
<td>9</td>
<td>$7,177.50 - $7,974.92</td>
<td>$86,130 - $95,699</td>
</tr>
<tr>
<td>10</td>
<td>$7,840.50 - $8,711.58</td>
<td>$94,086 - $104,539</td>
</tr>
</tbody>
</table>

- I authorize Leon County Health Department to release my medical information to the Community Health Partners with permission to fax and/or contact the client if necessary.

Client Signature ____________________________ Date ____________________________

Effective 01/28/2019
Florida Breast and Cervical Cancer Early Detection Program
CLIENT ENROLLMENT FORM

A. IDENTIFICATION/GENERAL INFORMATION (Please Print)

NAME:

Last  First  MI

MAILING ADDRESS:

Street  City  ZIP  County

TELEPHONE: (________) -  SSN: -

Other Contact Phone Number:  Your BIRTHDATE: ________

RACE – Choose ALL that apply:

WHITE  NATIVE HAWAIIAN or other PACIFIC ISLANDER  BLACK/AFRICAN AMERICAN

ASIAN  AMERICAN INDIAN or ALASKAN NATIVE  UNKNOWN

B. Do you have proof that you are a U.S. citizen or a non-citizen in a lawful status? YES NO

Do you have Hispanic or Latino heritage? YES NO

What is your primary Language spoken?

MARITAL STATUS: SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED

SCREENING STATUS: Have you ever participated in this program before? YES NO UNKNOWN

INSURANCE: NONE, MEDICARE (A or B), MEDICAID, HMO, PRIVATE

INCOME: Number in your household Total household monthly net income

HOW DID YOU HEAR ABOUT OUR PROGRAM? (Choose all that apply) Local ACS  Brochure  CHD  Community  Family/Friend  Internet  Bus Stop Advertisement

Newspaper  Postcard  Med. office. (Specify facility or clinical provider’s name):

C. BREAST EXAM BACKGROUND (Check only one box for each category)

1. Have you yourself ever been diagnosed with Breast Cancer?

Yes. If yes, when? No

2. Do you have a family history of breast cancer?

YES NO. If yes, Who?

3. When was your last MAMMOGRAM before enrolling in this program?

Last MAMMOGRAM (month/year) Location:

NONE UNKNOWN

D. CERVICAL EXAM BACKGROUND

1. Have you ever had Invasive Cervical Cancer? YES NO

If yes, when?

2. When was your last PAP SMEAR before enrolling in this program?

Last PAP SMEAR DATE (month/year) Location:

NONE UNKNOWN

3. Have you had a HYSTERECTOMY? (No Cervix) YES NO

FBCCEDP Client Enrollment Form Revised 10/09/19