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
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.
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.
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.
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
Name: ___________________________ Birthdate: ____________ SSN#: ____________

Address: ________________________________________________________________

Street ___________________________ City, FL ____________ Zip Code ____________

Phone number: ___________________________ Home ___________________________ Work/Cell ___________________________

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):

Unemployment Insurance Yes ☐ No ☐

Medicare Part A ☐ Part B ☐ Do you have Medicaid Yes ☐ No ☐

Do 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>
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<tr>
<td>7</td>
<td>$5,851.50 - $6,501.58</td>
<td>$70,218 - $78,019</td>
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<tr>
<td>8</td>
<td>$6,514.50 - $7,238.25</td>
<td>$78,174 - $86,859</td>
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<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__________?  ___ YES  ___ 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__________)  ___ NONE  ___ UNKNOWN

3. Have you had a HYSTERECTOMY? (No Cervix)  ___ Yes  ___ No

FBCCEDP Client Enrollment Form Revised 10/09/19