



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 FBCCEDP ineligible period.

Client signature

Date

Printed name

Date of birth



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.

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

- **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



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 _____)

NONE UNKNOWN

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