BREAST AND CERVICAL CANCER SCREENING ELIGIBILITY FORM

Eligibility Information

What is your age? | **Number of people in household:** | **Family's yearly income before taxes: $**

Do you have health insurance? ❑ Yes ❑ No | **Medicare Part B?** ❑ Yes ❑ No | **Medicaid?** ❑ Yes ❑ No

Yearly Deductible/Co-pay Amount: $ | **Insurance Company:**

Enrollment Information

Last Name | **First Name** | **Middle Initial** | **Social Security Number**

Other Last Names Used | **Date of Birth:** _____ *MM / DD / YYYY* | **County:**

Mailing Address: | **City:** | **State:** | **Zip:**

Home Phone: | **Cell Phone:** | **Email Address:**

Permission to leave confidential message on: (please circle) **Home phone:** YES/NO **Cell phone:** YES/NO

Are there any circumstances that might prevent you from receiving your cancer screening services?
❑ Lack of transportation ❑ Time off from work ❑ None ❑ Other, please describe:

Racial/Ethnic Background

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
❑ Other/Unknown

How did you hear about the program?

(check all that apply)

❑ Medical Provider Name:
❑ Family/Friend/Word of Mouth
❑ Re-screen/Previously enrolled
❑ Booth- Health fair, Pow Wow
❑ Presentation
❑ Pink/Purple Card (Pamphlets)

Please read and sign the Informed Consent and Authorization to Disclose Health Care Information on page 2

Medical Background

Primary Care Provider: _____

Are you having any breast problems? ❑ Yes ❑ No
Do you have breast implants? ❑ Yes ❑ No

Date of last mammogram: _____ *MM/DD/YYYY* ❑ Never had a mammogram

Healthcare facility of last mammogram: _____

Date of last Pap Test: _____ *MM/DD/YYYY* ❑ Never had a Pap test

Healthcare facility of last Pap? _____

Have you ever had a hysterectomy? ❑ Yes ❑ No
If yes, due to cervical cancer? ❑ Yes ❑ No ❑ Unknown
If yes, do you still have a cervix? ❑ Yes ❑ No ❑ Unknown

Family History:

History of breast cancer? (personal/family)
❑ Yes ❑ No ❑ Unknown
If yes, what is your relationship?

History of cervical Cancer? (personal/family)
❑ Yes ❑ No ❑ Unknown
If yes, what is your relationship?

Do you want us to schedule your exam? ❑ Yes ❑ No
Preferred facility to have mammogram: _____
Preferred facility to have Pap test: _____
Best time for appointments? (Circle) Mon. Tues. Wed. Thur. Fri.
Morning or Afternoon?

MT Quit Line: 1-800-QUIT-NOW

Do you use tobacco? ❑ Yes ❑ No Would you like a quit line coach to provide more information? ❑ Yes ❑ No
MT Tobacco Quit Line- Fax Referral Authorization to Release Information: Yes, I am ready to quit & ask that a quit line coach call me. I understand that the Montana Tobacco Quit Line will inform my provider about my participation.

Signature: _____ Date: _____

Updated 9/05/2024

Please Read and Sign Below

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Program (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 that 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 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	

Please fax completed form to the Montana Cancer Control Contractor in the client's area.

For clients living in **Judith Basin, Petroleum, Musselshell, Golden Valley, & Wheatland Counties,** send to:

Central Montana Health District
Public Health Programs
505 W. Main St., Suite 213
Lewistown, MT 59457
(406) 535-3983| Fax 535-3984
www.CentralMontanaHealthDistrict.org
one HEALTH

Tammy Jo Douglass, RN – *Cancer Control Specialist*
Central MT Health District – One Health
Fax (406) 535-3984, Phone: (406) 535-3983

For clients living in **Fergus County,** send to:

Sue Irvin – *Cancer Control Specialist*
Fergus County Health Department - Central Montana Family Planning
Fax (406) 535-9590, Phone (406) 535-8811