BREAST AND CERVICAL CANCER SCREENING ENROLLMENT FORM

Fax to: (406)258-4169

What is your age?	Primary Care Physician:	What is your family's yearly income before taxes?	Number of people in household?

Last Name	First Name	Middle Name	Other last names used?
Mailing Address	**City**	**State**	**Zip**
Email	**Social Security Number**	**Birth Date**	**County**

Phone Number	Circle one: Home/Cell/Work	Voice messages regarding eligibility & appointments okay? ❑ YES ❑ NO

Ethnic Background

Are you Hispanic? (Spanish/Hispanic/Latino) ❑ YES ❑ NO ❑ Unknown

Race: What race best describes you? ❑ White ❑ American Indian ❑ Alaska Native ❑ Asian

❑ Black/African American ❑ Native Hawaiian ❑ Pacific Islander ❑ Other/Unknown

Healthcare Coverage

Do you have Medicare Part B? ❑ YES ❑ NO

Do you have Medicaid? ❑ YES ❑ NO

Do you have health insurance? ❑ YES ❑ NO

Name: How much is the deductible?

Have you been referred to the Marketplace for health insurance or Expanded Medicaid?

❑ YES ❑ NO Referral Date

If you already have appointment(s) scheduled:

Date: **Time:**

Type: **Office Visit** **Pap** **Mammogram**

Location:

Provider:

Medical Background

Are you having breast problems? ❑ YES ❑ NO

Date of last mammogram? Location: ❑ Never had a mammogram

Do you have breast implants? ❑ YES ❑ NO

History of breast cancer? (personal/family) ❑ YES ❑ NO ❑ Unknown

Date of last Pap test? Location: ❑ Never had a Pap test

Hysterectomy? ❑ YES ❑ NO ❑ Unknown

If yes, due to cervical cancer? ❑ YES ❑ NO ❑ Unknown

If yes, do you still have a cervix? ❑ YES ❑ NO ❑ Unknown

Do you use tobacco? **MT QUIT Line: 1-800-QUIT-NOW**

❑ No

❑ Yes, I am ready to quit & ask that a QUIT Line coach call me. (Sign QUIT Line release on page 3.)

❑ Yes, but I do not want a Quit Line coach to call me

How did you hear about the program?

❑ Medical Provider:_____ ❑ Family/Friend ❑ Re-enroll ❑ Other: _____

U.S. Military Veterans

Are you a veteran of the U.S. Military? ❑ Yes ❑ No

If yes, can we share your contact information with a representative of the U.S. Department of Veteran Affairs? ❑ Yes ❑ No

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Please Read and Sign

Client Name:

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Centers 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, a woman may receive a pelvic examination and a Pap 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.

Patient Navigation Services

I understand if I do not meet the eligibility requirements for the MCCP and have chosen to enroll for patient navigation services only, MCCP is not financially responsible for any medical expenses incurred by me while enrolled for patient navigation services only.

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 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), the laboratory reading my Pap smear, 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:	Print Full Name:
Date:	

Montana Tobacco QUITLine - Patient Fax Referral Form Authorization To Release Information

Yes, I am ready to quit & ask that a QUITLine coach call me. I understand that the Montana Tobacco QUITLine will inform my provider about my participation.

Client Signature: