





# Florida Breast and Cervical Cancer Early Detection Program

## Annual Applicant Agreement

The Annual Applicant Agreement (AAA) is used to obtain authorization and information from eligible women enrolled in the Florida Breast and Cervical Cancer Early Detection Program (FBCC). The FBCC will collect participant Protected Health Information (PHI) and Personally Identifiable Information (PII) that is required to provide patient services.

Please read each statement below and agree by signing at the bottom of the document.

As an FBCC applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCC, and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level (FPL) and I have no health insurance that pays for breast and cervical cancer screening exams.
3. I will no longer be eligible for FBCC if my income changes to above 200% of the FPL.
4. I will call FBCC Once I obtain 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 FBCC.
5. I will disclose any breast or cervical screening services that may impact my eligibility of enrollment in FBCC.
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 tests 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 FBCC, 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 FBCC.
10. I agree to receive home phone, cellphone, email or postal mail contact from FBCC and the Department of Children and Families (DCF) Medicaid Program about my health care.
11. I understand that the FBCC 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 FBCC screening, I will be referred to DCF Medicaid Program which will determine if I am eligible for Medicaid benefits to cover treatment cost. I can reapply to FBCC 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 FBCC ineligible period.
14. **As authorized by federal law, Title 5 U.S. Code section 552a, collection of social security numbers by the Florida Department of Health for the FBCC may be necessary in order to apply for and receive Medicaid benefits.**

If you have any questions, contact your Regional Coordinator at the local Regional FBCC office:

Local Regional FBCC: \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

Client Email Address: \_\_\_\_\_



# Florida Breast and Cervical Cancer Early Detection Program (FBCC)

## FINANCIAL ELIGIBILITY

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **ID#** \_\_\_\_\_

1. Do you have Medicaid?  YES  NO **OR** Do you have Medicare?  YES  NO
2. Do you have any form of health insurance?  YES  NO Name of insurance \_\_\_\_\_
3. **Number of people in your Household.** \_\_\_\_\_ (include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes):** \$ \_\_\_\_\_ Month **OR** \$ \_\_\_\_\_ Year

Family Size	2023 DOH Scale Monthly Income	2023 DOH Scale Yearly Income
1	\$2,429.91	\$29,159.00
2	\$3,286.58	\$39,439.00
3	\$4,143.25	\$49,719.00
4	\$4,999.91	\$59,999.00
5	\$5,856.58	\$70,279.00
6	\$6,713.25	\$80,559.00
7	\$7,569.91	\$90,839.00
8	\$8,426.58	\$101,119.00
9	\$9,283.25	\$111,399.00
10	\$10,139.91	\$121,679.00

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

**NOTE:**

***If I obtain health insurance coverage, while under the FBCCP, it is my responsibility to notify the REGIONAL FBCC office as soon as possible.***

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

If you have any questions, please call the regional coordinator at 941-861-2928 \_\_\_\_\_ between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.



# Florida Breast and Cervical Cancer Early Detection Program Client Enrollment Form

LAST NAME:	<input type="text"/>	FIRST NAME:	<input type="text"/>	MAIDEN NAME:	<input type="text"/>	DATE OF BIRTH:	<input type="text"/>
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## 1. APPLICANT INFORMATION (Please complete each section of this application.)

<b>CONTACT INFORMATION</b>		<b>SCREENING STATUS</b> (Check only one response.)	
STREET ADDRESS:	<input type="text"/>	<input type="checkbox"/> Initial (first time in program)	<input type="checkbox"/> Rescreen (previously in program)
STREET ADDRESS:	<input type="text"/>	<input type="checkbox"/> Short-term interval follow-up or repeat exam (less than 300 days from last screening)	
CITY & ZIP CODE:	<input type="text"/>	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMAIL ADDRESS:	<input type="text"/>	If yes, what is the name of your insurance? <input type="text"/>	
PRIMARY PHONE:	<input type="text"/>	<b>DEMOGRAPHIC INFORMATION</b>	
ALTERNATE PHONE:	<input type="text"/>	<b>RESIDENTIAL AND CITIZENSHIP STATUS</b> (Check all that apply.)	
<b>BEST TIME TO REACH YOU:</b>		<input type="checkbox"/> Florida resident	<input type="checkbox"/> U.S. Citizen
<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.	<input type="checkbox"/> Citizen in lawful status	<input type="checkbox"/> Other
<input type="checkbox"/> Anytime		<b>ETHNICITY AND RACE IDENTIFICATION</b> (Check all that apply.)	
<input type="checkbox"/> Is it okay to leave a message?		<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Latino
PREFERRED APPT. DAY/TIME <input type="text"/>		<b>RACIAL IDENTITY</b>	
<b>HOW DID YOU HEAR ABOUT THIS PROGRAM?</b> (Check all that apply.)		<input type="checkbox"/> American Indian or Alaska Native	
<input type="checkbox"/> American Cancer Society	<input type="checkbox"/> Postcard	<input type="checkbox"/> Asian	
<input type="checkbox"/> Brochure	<input type="checkbox"/> Television	<input type="checkbox"/> Black or African American	
<input type="checkbox"/> County Health Department	<input type="checkbox"/> Radio	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> Community/Health Fair event	<input type="checkbox"/> Social Media	<input type="checkbox"/> White	
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Educational Session	<b>SPOKEN LANGUAGE(S)</b>	
<input type="checkbox"/> Internet/Website	<input type="checkbox"/> Bus wraps/benches/signs	Primary language spoken:	<input type="text"/>
<input type="checkbox"/> Private Medical Office	<input type="checkbox"/> Billboards	Additional language(s) spoken:	<input type="text"/>
<input type="checkbox"/> Newspaper	Name of Community Health Clinic: <input type="text"/>	Language preference to receive email:	
<input type="checkbox"/> Federally Qualified Health Center		<input type="checkbox"/> English	<input type="checkbox"/> Spanish
<input type="checkbox"/> Other		<b>BARRIERS</b>	
		Are there any barriers that would prevent you from keeping your appointments?	
		<input type="checkbox"/> Transportation	<input type="checkbox"/> Language
			<input type="checkbox"/> Disabilities
		Other (List) <input type="text"/>	

<b>FOR OFFICE USE ONLY</b>
Client Assigned ID# or Pseudo SS#:



# Florida Breast and Cervical Cancer Early Detection Program Client Enrollment Form

LAST NAME:	<input type="text"/>	FIRST NAME:	<input type="text"/>	MAIDEN NAME:	<input type="text"/>	DATE OF BIRTH:	<input type="text"/>
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## 2. HEALTH HISTORY

### GENERAL HEALTH STATUS (Check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pre-Diabetes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol

HEIGHT (in.):       WEIGHT (lbs.):

### BREAST EXAM BACKGROUND (Check all that apply)

Do you have breast implants?

Are you currently experiencing any issues with your breasts? Explain.

Have you ever been diagnosed with breast cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last mammogram before enrolling in this program? (Month/Year)

None  Unsure (2+ years)

Where was your last mammogram done? (Provider, City, State)

### FAMILY HISTORY

Has anyone in your family, such as your mother, sister, brother, or father, been diagnosed with breast cancer? If yes, which relative?

### TOBACCO USE (includes vaping, e-cigarettes, and similar products) (Check all that apply)

<input type="checkbox"/> Daily	<input type="checkbox"/> Were you given a referral to Quitline?
<input type="checkbox"/> Some days	<input type="checkbox"/> Declined referral
<input type="checkbox"/> Never/not at all	<input type="checkbox"/> I am interested in quitting.
<input type="checkbox"/> Declined to answer	

### CERVICAL EXAM BACKGROUND (Check all that apply)

Are you currently experiencing any issues with your cervix? Explain.

Have you ever been told by a doctor you have invasive cervical cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last Pap test before enrolling in this program? (Month/Year)

None  Unsure (10+ years)

Where was your last Pap test done? (Provider, City, State)

Have you ever had a hysterectomy? Specify whether partial or full.

Partial hysterectomy (I still have a cervix)  Full hysterectomy (no cervix)

What was the reason for the hysterectomy?

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:



# INITIATION OF SERVICES

## **PART I CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: \_\_\_\_\_

Name of Agency: \_\_\_\_\_

Agency Address: \_\_\_\_\_

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

\_\_\_\_\_By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

## **PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)**

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

## **PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)**

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

## **PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)**

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

## **PART V COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

## **PART VI MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

\_\_\_\_\_  
Client/Representative Signature

\_\_\_\_\_  
Self or Representative's Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

## **PART VII WITHDRAWAL OF CONSENT**

I, \_\_\_\_\_ WITHDRAW THIS CONSENT, effective \_\_\_\_\_  
Client/Representative Signature Date



**AUTHORIZATION TO DISCLOSE  
CONFIDENTIAL INFORMATION**

**INFORMATION MAY BE DISCLOSED BY:**

Person/Facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

**INFORMATION MAY BE DISCLOSED TO:**

Person/Facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

**METHOD OF DISCLOSURE:**

\_\_\_\_\_ Pick up at Clinic/Facility

\_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Fax #: \_\_\_\_\_

\_\_\_\_\_ Email Address: (please note that emailing may not be a secured method of communication)

**INFORMATION TO BE DISCLOSED:** (Initial Selection)

- \_\_\_\_\_ General Medical Record(s)      \_\_\_\_\_ STD Records      \_\_\_\_\_ TB Records      \_\_\_\_\_ History and Physical Results
- \_\_\_\_\_ Immunizations      \_\_\_\_\_ Family Planning      \_\_\_\_\_ Prenatal Records      \_\_\_\_\_ Consultations
- \_\_\_\_\_ Progress Notes
- \_\_\_\_\_ Diagnostic Test Reports (Specify Type of test(s) \_\_\_\_\_)
- \_\_\_\_\_ Other: (specify) \_\_\_\_\_

**I specifically authorize release of information relating to: (initial selection)**

- \_\_\_\_\_ HIV test results      \_\_\_\_\_ Substance Abuse Service Provider Client Records
- \_\_\_\_\_ Psychiatric, Psychological or Psychotherapeutic notes      \_\_\_\_\_ Early Intervention      \_\_\_\_\_ WIC

**PURPOSE OF DISCLOSURE:**

\_\_\_\_\_ Continuity of Care      \_\_\_\_\_ Personal Use      \_\_\_\_\_ Other (specify) \_\_\_\_\_

**EXPIRATION DATE:** This authorization will expire (insert date or event) \_\_\_\_\_. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

**REDISCLASURE:** I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**CONDITIONING:** I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

**REVOCAATION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

\_\_\_\_\_  
Client/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Legal Representative's Relationship to Client

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).

**Client Name:** \_\_\_\_\_

**ID#:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Original:** To File    **Copy:** To Client    **Copy:** To Accompany Disclosure