FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM FBCCEDP

(Serving Sarasota, Manatee, Desoto, Charlotte, Lee, Hendry, Glades and Collier Counties.

Mammograms, Clinical Breast Exam- Pap and Pelvic Exams for women.- Ages 50-64

PATIENT ENROLLMENT - **Fax to : 941-554-5512**

Demographics

Legal Last Name: ________________________ Legal First Name: ____________________ MI: ____

Date of Birth: _____-___-_____ SSN: ____/____/______ Phone (Home): __________ Cell Phone: ___________

Mailing Address: ________________________City: ______________ County ______________ Zip Code ________

E-Mail Address: ______________________@_______________

Ethnicity: Hispanic or Latina? Yes ☐ No ☐

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ American Indian or Alaska Native ☐ Unknown Primary Language (If Other than English): __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

May we leave detailed message on your voice mail? ☐ Yes ☐ No

Medical History

Height: _____ Weight: ____

Do you have any of the following conditions? (Please check all that apply)

☐ Pre-Diabetic ☐ Diabetic ☐ High Blood Pressure ☐ High Blood Cholesterol

Tobacco Use: ☐ *Daily* ☐ *Some Days* ☐ *Not at all* *Referred to Quit Line: ☐ Yes ☐ No

How did you learn about the program?

☐ ACS ☐ Brochure ☐ CHD ☐ Community ☐ Family/Friend

☐ Internet ☐ Med Office ☐ Newspaper ☐ FQHC ☐ Postcard ☐ Bus Wraps/Bench/Placards ☐ Educational Session ☐ In-Reach ☐ Outreach ☐ Radio ☐ Billboards ☐ Social Media ☐ Television

When was the last time you had any type of health insurance? _______

BREAST

Have you had breast cancer? ☐ Yes ☐ No

Have you had a mammogram before? ☐ Yes ☐ No If yes, prior mammogram date _____/_____

Where did you have your last mammogram (Name of facility and location)? ______________________________

Are you having any breast symptoms (i.e. lumps, discharge and/or pain)? ☐ Yes ☐ No

Do you have breast implants? ☐ Yes ☐ No

Has anyone in your family had breast cancer? ☐ Yes ☐ No

If "yes" circle one if other, please specify: Mother/Daughter/Sister/Other: ___________Age of Diagnosis: ____

Have you had a MRI of the breast within the last two months? ☐ Yes ☐ No If yes, date of MRI ___/____

CERVICAL

Have you had a Pap Smear ☐ Yes ☐ No If yes, prior pap smear date _____/_______

Have you ever had invasive cervical cancer? ☐ Yes ☐ No If yes, please explain_____________________________

Have you had a hysterectomy? (Have you had surgery to remove your uterus & cervix?) ☐ Yes ☐ No
If yes, date of surgery _____/_____

Are you receiving primary care services? ____ If yes where? ___________ Phone Number: _____________

Are you currently taking blood thinners? ☐ Yes ☐ No

Do you need a wheelchair the day of your appointment? ☐ Yes ☐ No

Florida Breast and Cervical Cancer Early Detection Program
Self-Declaration Statement - FAX to 941-554-5512

NAME: _________________________________SSN:_______________________

Please circle your family size. Write in your monthly or yearly income.
Your gross income must be equal to or less than the amount listed for
your family size. Family is defined as spouse, minor child (Biological, adoptive, or stepchildren) and any partner in which a mutual minor child living in the same home.

Family Size:	2019 Federal Scale Monthly Income:	Your Family Monthly income:	2019 Federal Scale Annual Income:	Your Family Yearly Income:
1	$2,082		$24,980	
2	$2,819		$33,820	
3	$3,555		$42,660	
4	$4,292		$51,500	
5	$5,029		$60,340	
6	$5,765		$69,180	
7	$6,502		$78,020	
8	$7,239		$86,860	
9	$7,975		$95,700	
10	$8,712		$104,540	

- ☐ **I do not have Medicaid**
- ☐ **I do not have Medicare**
- ☐ **I do not have Health Insurance**

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.

I further understand that all my screening and diagnostic procedures must be completed within 45 days or payment for these services CANNOT be guaranteed.

Signature: ___________________________________Date: ________________

03/2019

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

Beth McCabe
Senior Human Services Program Specialist

Florida Department of Health
Florida Breast & Cervical Cancer Early Detection Program
2200 Ringling Blvd.
Sarasota, FL 34237

PHONE: 941-861-2676
FAX: 941-554-5512

Beth.McCabe@flhealth.gov
www.sarasotahealth.org