FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM
(FBCCEDP)
Serving Sarasota, Manatee, Desoto, Charlotte, Lee, Hendry, Glades and Collier Counties.
Mammograms, Clinical Breast Exams,
Pap and Pelvic Exams for women.
Ages 50-64
PATIENT ENROLLMENT
Fax to 941-544-5512

Please complete and return the entire application- any blanks may result in a delay of scheduling your appointment. Please write clearly!!!

We have several Health Providers that are utilized for the Clinical Breast Exams (CBE) and Pap Tests. If you do not have an order for your mammogram, a CBE must be completed before your mammogram is scheduled. Pap Smears are done based on your individual medical history which will be determined by the provider. Pap Smears are usually done every 3 to 5 years unless there is a current problem.

Please indicate your preference for day of the week and time of day for your appointments on the Appointment Scheduling Page.

Once these forms are received we will schedule your appointments. We will also send you a voucher to take with you for payment purposes. Please keep in mind we are currently processing a high volume of applications. Please allow **TWO WEEKS** before you call to inquire on the status of your application. We will contact you when we can schedule your appointment.

If you have any questions, please contact the following:

Nikki Robinson 941-861-2721
Beth McCabe 941-861-2676
Jan Chulock 941-861-2928

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Name and Location of clinic:

Client over the age of 50 enrolled for. ☐ Mammogram ☐ Clinical Breast Exam ☐ Pap (see guidelines)

Legal Last Name: _____ Legal First Name: _____ MI: ____

Social Security Number: _____-___-_____ Date of Birth: ____/____/_____

Address: _____

City: _____, FL Zip: _____ Best time to call: _____

County: _____

Phone (Home): _____ Cell Phone: _____

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

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Eskimo ☐ Native Hawaiian

☐ Aleutian Islander ☐ Pacific Islander

Ethnicity: ☐ Hispanic or Latina ☐ Jewish

Primary Language (If Other than English): _____

Would you like to list an alternate contact in the event we are unable to reach you? ____

Name: (Last, First) _____ Relation to you: _____

Phone Number: _____

May we leave messaged with this alternate contact? ____

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? _____

Medical History:

Height: _____ Weight: ____
Mandatory question: Tobacco Use: ☐ *Daily* ☐ *Some Days* ☐ *Not at all*
***Referred to Quit Line: ☐ Yes ☐ No**

Have you had breast cancer? ☐ Yes ☐ No

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

If "yes" circle one if other, please specify: Mother/Daughter/Sister/Other: _____

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

Do you have breast implants? □ Yes □ No

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 _____/_____

Where are you receiving primary care services from? _____

Phone Number: _____

Are you currently taking blood thinners? □ Yes □ No

Do you have and/or do any of the following? (Please check all that apply)

□ Pre-Diabetic □ High Blood Pressure □ Exercise 5x Weekly □ Diabetic □ High Blood Cholesterol □ Eat 5 Servings of fruits/vegetables daily

Revised 09/2018

Please Note: The program will make every attempt to schedule you at the facility closest to your home at a time that matches your preferences. However, due to limited availability we may not be able to accommodate your requests. We appreciate your cooperation and understanding in this matter. Due to the volume of clients waiting for services, missed appointments will be rescheduled as appointment times become available. Please call your mammogram facility a minimum of 24 hours in advance if you are not able to keep your appointment as well as reschedule your appointment at the time of the call. After rescheduling your mammogram appointment please call us and inform us of your new mammogram date and time so we can ensure your voucher is updated.

Appointment Scheduling

Check the box below and indicate your time and day of preference. We will try to accommodate you; however, the facilities have set scheduling hours.

Time Preference

□ Anytime □ Early Morning □ Mid-Morning □ Late Morning □ Afternoon □ Mid Afternoon □ Late Afternoon □ Evening

Day of the week preference (Check all that apply)

□ Any day □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday if available

Please advise of any dates that you are NOT available. _____

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

*** If you have an order for a mammogram you must send it in with this application. ***
***Please make sure that you have completed the Annual Applicant Agreement form. We CANNOT schedule you for your mammogram without this form! ***

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:	2018 Federal Scale Monthly Income:	Your Family Monthly income:	2018 Federal Scale Annual Income:	Your Family Yearly Income:
1	$2,024		$24,280	
2	$2,744		$32,920	
3	$3,464		$41,560	
4	$4,184		$50,520	
5	$4,904		$58,840	
6	$5,624		$67,480	
7	$6,344		$76,120	
8	$7,064		$84,760	
9	$7,784		$93,400	
10	$8,504		$102,040	

- ☐ 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: _____
09/2018

Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

- I want to become a client of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP).
- Florida is my primary residence.
- **I declare that my net family annual income is at or below 200% of the federal poverty guideline and I have no health insurance that pays for breast and cervical cancer screening exams**.
- I understand I am no longer eligible for the FBCCEDP if my income changes to be above 200% of the federal poverty guideline or if I enroll in any health insurance program that provides breast and cervical cancer screening.
- I understand that I may have a share of cost for some services.
- I agree to use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test) and I agree to complete any follow-up tests within 60 days.
- I understand that the FBCCEDP is a breast and cervical cancer **screening** program, not a cancer **treatment** program.
- If I am diagnosed with breast or cervical cancer as a result of my FBCCEDP screening, I will be referred to the Department of Children and Families who will determine if I am eligible for Medicaid to cover my treatment cost. I understand I can reapply to the FBCCEDP for screenings after initial treatment is completed.
- I agree to allow an exchange and release of information between my health care providers, the Florida Department of Health Breast and Cervical Cancer Early Detection Program, the Florida Department of Health Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination results, and any follow up tests and treatments done as a result of the examination, even if the tests or treatment I receive are not paid for by the FBCCEDP.
- I agree to receive phone or mail contact from FBCCEDP staff about my health care.
- I understand this agreement is good for one year unless my program eligibility changes.
- I understand that taking part in this program is my choice and I may withdraw from the program at any time.

_____ _____

Client signature Date

_____ _____

Printed name Date of birth

Revised 07/01/2016

Florida HEALTH