FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (FBCCP)

(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: _____ Middle Name: _____
Maiden Name: _____ Date of Birth: _____ Phone: _____ ☐Cell ☐Home
Mailing Address: _____City: _____ County _____ Zip Code _____
E-Mail Address: _____ Alternate Contact Phone #: _____
May we leave detailed messages on your voice mail? ☐Yes ☐No Ethnicity: Hispanic or Latina? ☐Yes ☐No
Residential and Citizenship Status (Check all that apply): ☐Florida Resident ☐U.S. Citizen ☐Alien Status
Race: (you may select more than one) ☐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

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? _____
Have you or your spouse recently lost income due to COVID-19? ☐Yes ☐No

Medical History

Height (in feet and inches): _____ Weight (in lbs.): _____
Do you have any of the following conditions? (Please check all that apply)
☐Pre-Diabetic ☐Diabetic ☐High Blood Pressure ☐High Blood Cholesterol
Tobacco Use (including Vaping): ☐Daily ☐Some Days ☐Not at all *Referred to Quit Line: ☐Yes ☐No
Are you receiving primary care services? ☐Yes ☐No If yes, where? _____ Phone #: _____
Do you require a wheelchair the day of your appointment? ☐Yes ☐No

BREAST

Have you had breast cancer? ☐Yes ☐No
Have you had a mammogram before? ☐Yes ☐No If yes, date of the prior mammogram _____/_____/_____
Where did you have your last mammogram (Name of Facility and location): _____
Are you experiencing any breast symptoms (i.e. Lumps, Discharge and or Pain? ☐Yes ☐No If yes, please list the type of symptom: _____ In which breast do you experience the symptom: ☐Left ☐Right ☐Both
Do you have breast implants? ☐Yes ☐No Has anyone in your family had breast cancer? ☐Yes ☐No
If yes, please list how this person(s) are related to you: ☐Parent ☐Child ☐Sibling ☐Other: _____
Have you had a breast MRI within the last two months? ☐Yes ☐No If yes, when? _____

CERVICAL

Have you ever had a Pap smear? ☐Yes ☐No If yes, date of last 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 and cervix? ☐Yes ☐No
If yes, date of your surgery: _____

Do you prefer appointments in the morning or afternoon? _____
What day(s) of the week would you prefer an appointment? _____

Revised 08/19/2020

SUNSHINE

Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

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	2020 DOH Scale Monthly Income	2020 DOH Scale Yearly Income
1	$2,126.58	$25,519.00
2	$2,873.25	$34,479.00
3	$3,619.92	$43,439.00
4	$4,366.58	$52,399.00
5	$5,113.25	$61,359.00
6	$5,859.92	$70,319.00
7	$6,606.58	$79,279.00
8	$7,353.25	$88,239.00
9	$8,099.92	$97,199.00
10	$8,846.58	$106,159.00

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 FBCCEDP, it is my responsibility to notify the REGIONAL FBCCEDP office as soon as possible.

Signature _____

Date_____

If you have any questions Please call the regional coordinator Jan Chulock 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

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 (FBCCEDP). The FBCCEDP 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 FBCCEDP applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCCEDP, 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 FBCCEDP if my income changes to above 200% of the FPL.
4. I will call FBCCEDP 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 FBCCEDP.
5. I will disclose any breast or cervical screening services that may impact my eligibility of 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 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 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 home phone, cellphone, email or postal 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 which will determine if I am eligible for Medicaid benefits 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 FBCCEDP 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 FBCCEDP 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 FBCCEDP office:

Local Regional FBCCEDP: **Sarasota** Phone #: **941-861-2928**

_____ _____
Client Signature Date

_____ _____
Printed Name Date of Birth

Client Email Address: _____

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: Florida Department of Health in Sarasota County

Agency Address: 2200 Ringling Blvd., Sarasota, FL 34237

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.

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.

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

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

Original to file; Copy to client

DOB: _____

DH 3204-SSG-09-2019

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Florida Department of Health in Sarasota County **Phone #:** 941-861-2676

METHOD OF DISCLOSURE:

_____ **Pick up at Clinic/Facility**

_____ **Address:** _____

_X_ **Fax #:** 941-554-5512

_____ **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:

_X_ 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.

REDISCLOSURE: 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.

REVOCATION: 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