



MONTANA
**CANCER CONTROL
PROGRAMS**

MCCP Breast and Cervical Cancer Screening Enrollment Form



Eligibility-Enrollment Information

What is your age?	Family's yearly income before taxes?	Number of people in household?		
Last Name	First Name	Middle Initial	Other Last Names Used	
Birth Date	Social Security Number			
Mailing Address	City	State	Zip	County
Phone Numbers (Is it ok to leave messages regarding eligibility/appointments on these phones?) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Home Phone number: () -		Cell Phone number: () -		E-Mail Address

Ethnic Background	Race Check all races that apply.
Are you Hispanic? (Spanish/Hispanic/Latino)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown

Healthcare Coverage

Do you have Medicare Part B? Yes No Do you have Medicaid? Yes No Do you have health insurance? Yes No

If Yes, name of Insurance Company _____

What is the deductible and/or co-pay amount? _____

Medical Background

Are you having any breast problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a Pap test? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Pap test ____ / ____ / ____
Date of last mammogram ____ / ____ / ____	Have you had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Do you have breast implants? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, was it due to cervical cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Do you have a personal or family history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, do you still have a cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Do you use tobacco? Yes No **Tobacco Use Cessation** **MT Quit Line: 1-800-QUIT-NOW**

Are there any circumstances that might prevent you from receiving your cancer screening services?

Please describe those circumstances below, if none, check None. Lack of transportation Time off from work None

Other, please describe: _____

How did you hear about the program? (Check all that apply)

Medical Provider (Name of Provider) _____

Internet Pamphlets/Flyers TV Re-screen/Previously Enrolled Family/Friend/Word of Mouth
 Presentation MAIWHC Fair-Job/Health or Pow Wow Special Promotion/Promotional Ad Newspapers/Newletters
 Government Office Radio Other _____



Please Read and Sign the Informed Consent and Authorization to Disclose Health Care Information.



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 Center 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 screening, she may receive a Pap test and/or an HPV 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. I understand if I have Medicare Part B or Medicaid, I am not eligible for financial assistance.

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 up to the maximum allowable Medicare reimbursement rate 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 healthcare 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 healthcare provider(s), 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: _____ Date: ____/____/____

Print Full Name: _____