ST. CLAIR COUNTY HEALTH DEPARTMENT

19 PUBLIC SQUARE, SUITE 150
BELLEVILLE, ILLINOIS 62220-1624
https://www.co.st-clair.il.us

Cindy Thompson, RN, BSN
President

Myla Blandford, MPH, REHS, LEHP
Executive Director

Administrative/Fiscal
618.233.7703
618.222.1630 fax

Infectious Disease Prevention
- **Communicable Disease**
  618.233.6175
  618.233.9356 fax
- **Southwestern Illinois HIV Care Connect**
  618.825.4501
  618.825.4585 fax
- **Emergency Preparedness**
  618.233.7703
  618.233.9356 fax

Personal Health
- **Maternal-Child Health Programs**
  618.233.6170
  618.236.0821 fax
- **Breast and Cervical Cancer**
  618.233.7703
  618.233.7713 fax

Environmental Health
- 618.233.7769
- 618.236.0676 fax

Like and Follow us on:
Facebook: *@SCC.HealthDepartment*
Twitter: *@stclairhealth*

Public Health
Prevent. Promote. Protect.
St. Clair County Health Department
together for your health

Hello,

Welcome to the Breast & Cervical Cancer Program. Enclosed is the paperwork that I need you to complete in order to enroll in our program. Please be sure to sign at all signature spaces, please look at both sides of every page, and complete all requested information to the best of your ability. Incomplete forms will not be processed, they will be returned to you for completion.

(Please note that we need household income, so if you have a spouse, we need his/her proof of income also.

You may bring these to our office if you would like us to copy your ID and income information. It is best to call first to be sure we are available.

Once your forms have been received and verified, we will begin to make appointments. Do not make your own appointments. We will only pay for those appointments that are made by our staff, as we are very limited in the services for which we can pay, and do not want you to get charged for unexpected services. An appointment sheet will be sent to you for your appointments, and our nurse will call you with the dates and times.

If you have any questions, please call 618-825-4408

We look forward to working with you.

The Staff of the Breast & Cervical Cancer Program.

Please read the reverse side of this form also

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM ENROLLMENT PACKET

CHECKLIST

Please complete the attached enrollment papers to the best of your knowledge. ***Signing and dating*** of required forms will be necessary prior to our being able to schedule your appointments. Simply check them off as you complete them.

☐ **Eligibility Determination Form**
Complete, sign & date

☐ **Health Assessment** (Breast and Cervical Screening Questions)
Complete to the best of your knowledge

☐ **Cornerstone Consent Form**
Please read the entire form and then complete, sign & date. This gives IBCCP Personnel permission to enter the information you provided into our computer system. Only the IBCCP Personnel have access to this information. This allows the IBCCP Personnel to keep your breast and cervical cancer screenings up-to-date, on a yearly basis.

☐ **Client Participation Agreement & Release of Information**
Please read, sign & date

☐ **Authorization to Obtain Information**
Please read, sign and date

☐ **Joint Notice of Privacy Practices and Consent**
Please read, sign and date

Please include the following verification with your enrollment/re-enrollment packet.

☐ **Income** Verification (2 most recent paycheck stub or recent 1040 tax form)
☐ **Age** Verification (copy of your driver's license, ID card or birth certificate)
☐ **Medicaid Verification** (copy of your card)
☐ **Insurance Verification** (copy of the front and back of your card)

If you have any questions while completing these forms, please call us at (618)825-4408

Sincerely
IBCCP staff

Illinois Breast and Cervical Cancer Program
Eligibility Determination Form

Shaded area is for IBCCP office use only

☐ New Client Registration Date: _____	☐ Established Client Annual Date: _____	☐ Navigation Only Date: _____	Cornerstone # _____

Name: _____

Previous Last Name: _____

Age: _____ Birth Date: _____/_____/_____

Address: _____

City: _____ State: _____

Zip Code: _____ County: _____

Home Phone: _____

Cell Phone: _____

Day Phone: _____

Medical/Insurance Coverage: *Check all that apply.*

- ☐ Medicare Part B – Not eligible for IBCCP
- ☐ Medicaid ID number _____
- ☐ I DO NOT have insurance
- ☐ I have Insurance – Name of Carrier: _____
- ☐ Are you covered under a parent or spouse insurance? ☐ No ☐ Yes

If yes, Insurer Name: _____

Does insurance pay for: Pap tests? ☐ No ☐ Yes
Mammograms? ☐ No ☐ Yes

Do you have a deductible that must be met before diagnostic procedures are covered? ☐ No ☐ Yes

Please provide a copy of the front and back of your insurance card.

Employment Status:

- ☐ Employed full-time (35+ hours weekly) (EFT)
- ☐ Employed part-time (EPT)
- ☐ Not in the labor force (NLF)
- ☐ Seasonal/Migrant Farm Worker (SMF)
- ☐ Self-employed (SE)
- ☐ Temporary Worker (TW)
- ☐ Unemployed (UNE)

Marital Status:

- ☐ Never Married (01)
- ☐ Married (02)
- ☐ Other: _____

Years of Education Completed:

- ☐ _____ (EO # of years)
- ☐ Unknown (E099)

Income determination:

Total income before taxes (if married - total combined income before taxes): $_____ (circle one) per month/year

Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: _____

Office Use Only: Income status for number in household:

At or below 250% of federal poverty level: ☐ Above 250% of federal poverty level: ☐

Are you of Hispanic or Latino origin?

☐ Yes (01) ☐ No (00)

Preferred language for delivery of service:

- ☐ English (E)
- ☐ Spanish (S)
- ☐ Other (O): _____

What races do you consider yourself? Mark ALL that apply.

- ☐ White
- ☐ Black or African American
- ☐ Asian
  - ☐ Chinese ☐ Indian ☐ Japanese
  - ☐ Vietnamese ☐ Korean ☐ Filipino
  - ☐ Other _____
- ☐ Native Hawaiian/Other Pacific Islanders
- ☐ American Indian/Alaskan Native

How did you hear about this program?

- ☐ Poster (PO)
- ☐ Flier (FL)
- ☐ Brochure (BR)
- ☐ Community Navigator (C)
- ☐ Community Event (CE)
- ☐ Physician or Health Care Provider (P)
  Who: _____ Phone #: _____
- ☐ Other (OTH), Specify: _____
- ☐ Newspaper (ME)
- ☐ Radio (ME)
- ☐ Television (ME)
- ☐ Website (Agency/State) (WB)

Barriers:

☐ None ☐ Transportation ☐ Child/family Care ☐ Work schedule
☐ Understanding medical needs ☐ Special needs ☐ Financial
☐ Need Interpreter ☐ Travel Distance ☐ Making appointments
☐ Other: _____

Comments:

_____

_____

What is the best time to schedule your appointments?

(Please mark your choices.) **Preferred Healthcare Provider:** _____

Day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time of day: ☐ Early morning ☐ Mid-morning ☐ Early afternoon ☐ Late afternoon

I certify that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature _____ **Date** _____

Please complete reverse side also

IBCCP Health Assessment

Name: **Date:**

YES	NO	BREAST HEALTH QUESTIONS
☐	☐	1. Do you routinely check your breasts for changes?
☐	☐	2. Have you noticed a lump in your breasts?
☐	☐	3. If yes, which breast? Right___ Left____
☐	☐	4. Have you noticed any breast tenderness or pain?
☐	☐	5. If yes, did the breast tenderness or pain increase around the time of your menstrual period?
☐	☐	6. If you answered yes to question #4, which breast? Right _____ Left_____
☐	☐	7. Have you noticed any spontaneous discharge (not from stimulation or squeezing) from your nipples?
☐	☐	8. If yes, which breast? Right _____ Left_____
☐	☐	9. Have you noticed any other symptoms related to your breasts? If yes, explain: _____
☐	☐	10. Have you ever had a breast exam done by a doctor or nurse?
☐	☐	11. If yes, list provider/clinic where breast exam was done: _____
☐	☐	12. If yes, date of last exam (before this current visit): _____/_____
☐	☐	13. Have you ever had a mammogram?
☐	☐	14. If yes, list provider/clinic where mammogram was done: _____
☐	☐	15. If yes, date of your last mammogram (before this current visit):___/_____
☐	☐	16. If unknown was it more than 5 years?
☐	☐	17. Have you ever had breast cancer?
☐	☐	18. Has your mother, father, sibling (sister/brother), daughter or son had breast cancer? If no, go to question 22.
☐	☐	19. If yes to #18, who _____
☐	☐	20. Are they BRCA positive (if unknown leave blank)?
☐	☐	21. If yes to #18, at what age? _____ years old
☐	☐	22. Do you have a breast implant or implants?
☐	☐	23. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
☐	☐	24. If yes, which breast? Right _____ Left_____
☐	☐	25. If yes, list the provider who performed the procedure_____
☐	☐	26. Have you ever had radiation to the chest area?

YES	NO	CERVICAL HEALTH QUESTIONS
☐	☐	27. Have you ever had a Pap test?
☐	☐	28. If yes, list provider where Pap test was done: _____
☐	☐	29. If yes, date of last Pap test: (before this current visit) ___/____
☐	☐	30. If date unknown, was it more than 10 years ago? Please guess and write the date in #29.
☐	☐	31. Were your last Pap test results normal?
☐	☐	32. What was the date of your last menstrual period? _____/_____/_____
☐	☐	33. Are you pregnant?
☐	☐	34. Have you had a hysterectomy?
☐	☐	35. If yes, was your cervix removed? I do not know_____
☐	☐	36. If you had a hysterectomy, was it due to a past history of cervical disease or cervical cancer?
☐	☐	37. Were you exposed to Diethylstilbestrol (DES)?
☐	☐	38. Is your immune system weakened in any way? (medication, HIV, organ transplant or other health condition)

YES	NO	TOBACCO QUESTIONS
☐	☐	39. Do you smoke cigarettes?
☐	☐	40. If yes, are you ready to quit smoking?
☐	☐	41. If yes, are you interested in being referred to the Illinois Tobacco Quitline?

(Shaded area for IBCCP office use)

42. What date was the referral sent to the Tobacco Quitline?
___/___/___

BARRIER/RISK ASSESSMENT QUESTIONS

Barrier Assessment

43. from Eligibility Determination form

Breast Cancer Risk Assessment

(from Summary Office Visit form)

44. Life time risk_____

45. High risk for breast cancer

- ☐ yes, client is high risk
- ☐ no, client is not high risk
- ☐ not assessed/unknown

Cervical Cancer Risk Assessment

46. High risk for cervical cancer

- ☐ yes, client is high risk
- ☐ no, client is not high risk
- ☐ not assessed/unknown

STATE OF ILLINOIS
CORNERSTONE
CORNERSTONE INFORMED CONSENT FORM

Name of Participant:

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (Month/Day/Year) _____ ○ Male ☒ Female Participants ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; Healthy Families Illinois; and Family Health History Questionnaire/Genetics.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Department of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client s name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize St. Clair County Health Department (Cornerstone site)
to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal; birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program; and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared;

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Department of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photostatic copy/fascimile of this consent will be as valid as the original.

For Child Participant: For Adult Participant:

_____ OR X _____

Signature of parent/legal guardian/caretaker/Date Signature of adult participant/Date

Signature of Witness: _____ Date: _____

Revised April 2011

Please read and sign reverse side also if indicated

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION

I. PROGRAM DESCRIPTION:

The Illinois Breast and Cervical Cancer Program (program) is a cooperative effort between the Illinois Department of Public Health, Office of Women's Health and Family Services, and the U.S. Centers for Disease Control and Prevention (CDC). The program encourages routine breast and cervical cancer screening and provides free screening and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screening is to detect cancer, if present, at an early stage so it can be treated or cured. Screening for breast cancer involves a clinical breast examination and a mammogram (a breast X-ray). Screening for cervical cancer involves a pelvic examination and a Pap test (scraping from the cervix).

II. CONSENT TO PARTICIPATE AND RELEASE OF INFORMATION:

I understand and agree to the following:

- I will provide proof of age and income to determine program eligibility. If I have insurance coverage, I will provide a copy of my insurance card and written verification of covered services. If while enrolled in IBCCP I obtain insurance, I will inform Lead Agency staff.

- I give permission to my health care provider(s), insurance company, hospital, clinic, laboratory and/or mammography facility to provide information concerning my breast and cervical cancer screening, diagnostic examinations and/or treatment status to program staff.

- I understand that the program must obtain certain statistical information for reports, including but not limited to age, income, insurance and any services I am provided through this program. This information may be used by the program and the CDC to learn more about breast and cervical cancer and to ensure the quality of services provided through the program. **My name will not be used in these reports, except as required by law.**

- My health care provider and/or the program staff will try to contact me regarding my test results. I understand that, despite efforts to find me, my health is my own responsibility and I may need to contact my provider for my test results.

- I understand that if the provider orders tests not covered by the program or my insurance that I may be responsible for payment of those IBCCP services as the program cannot pay for some diagnostic exams. A list of allowable services is available upon request.

- If I am diagnosed with a pre-cancerous or cancerous condition of my breasts or cervix, information from my IBCCP file will be released to the Illinois Department of Healthcare and Family Services. This information will be used to determine if I am eligible for state paid health benefits through Medicaid.

- If I am not eligible for Medicaid coverage, the program staff will assist with referral for treatment services through private sources, community based sources, other governmental grants or pro bono from a provider.

- If I am eligible for state paid health benefits through Medicaid, I give my permission for program staff to obtain information about my treatment for breast or cervical cancer. This information will be used to determine my treatment status and my continued enrollment in Medicaid.

- I will receive notification from the program staff to remind me when it is time for me to go back to my medical provider for my annual examination and follow-up testing, if appropriate (This does not apply to insured clients).

- I will notify the program of any change in my address and/or telephone number.

- I will write or call the local program staff to inform them if I no longer wish to be a part of this program. This notification will be recorded in my program records.

- I understand the importance of keeping all appointments made for me so my care can be provided in a timely manner. When it is necessary to cancel or change an appointment, I will notify the agency of this change.

- Missed appointments or repeated "no show" appointments are not acceptable and I can potentially lose my ability to receive IBCCP services if this happens.

Please read and sign reverse side also if indicated

III. ACKNOWLEDGMENTS:

- I have received literature and/or education on all of the following: breast health, mammograms, and Pap tests. _____ (initial here)

- The University of Illinois at Chicago (UIC), an IBCCP partner, conducts an annual survey for the purpose of helping the Department improve the quality of the program so that the Department can provide better services to program participants. UIC will be contacting you about this survey at a future date. We hope that you will participate, but your participation is completely voluntary, and your program eligibility will not be affected if you choose not to participate. Your initials here acknowledge that you have received notification of this voluntary survey. _____ (initial here)

Client Signature _____ **Date** _____

Request for Confidential Communications

I am requesting to receive all communications about my protected health information from St. Clair County Health Department at a location by alternate means. I am requesting to receive communications from St. Clair County Health Department at the location(s) stated below:

Name	Address	Telephone #
Name	Address	Telephone #
Name	Address	Telephone #

Client Signature: _____ Date: _____

St. Clair County Health Department

Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read and receive the Notice of Privacy Practices for the St. Clair County Health Department, and to have any of my questions answered before signing.

I understand that I have the right to request restrictions to the use and disclosure of my protected health information by submitting request in writing to the St. Clair County Health Department Chief Privacy Office.

I understand that I have the right to request confidential communications by completing the *backside* of this form.

Client Signature: _____ **Date:** _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

[ ] Parent or guardian of minor patient

[ ] Guardian or conservator of an incompetent patient

[ ] Beneficiary or personal representative of deceased patient

FOR OFFICE USE ONLY:

If patient or patient's representative refuses to sign this Acknowledgment:

[ ] Efforts to Obtain: _____

[ ] Reason patient refused to sign: _____

Employee Signature: _____ Date_____

Please read and sign reverse side also if indicated

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH AND FAMILY SERVICES
BREAST AND CERVICAL CANCER PROGRAM

AUTHORIZATION TO OBTAIN INFORMATION

I hereby give consent to release the following information:

☒ Clinic Report
☒ Medical Reports
☒ Laboratory Report
☐ Other _____

Regarding:
Client's Name: _____

Client's Address: _____

Date of Birth: _____/_____/_____

To: Agency Name & Address, ATTN: Illinois Breast & Cervical Cancer Program

St Clair County Health Department

19 Public Square, Suite 150

Belleville, IL 62220

Phone: (618)825-4408

I agree to release said provider, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice. Unless I revoke sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photo static copy or facsimile of this consent will be valid as the original, even though such copy does not contain the original writing of my signature.

X _____ X _____
Signature Date

_____ _____
Witness Date

Notice of Privacy Practices

St. Clair County Health Department

The Department's Notice of Privacy Practices describes how your medical information may be used and disclosed; and how you can get access to this information.

This notice is available on our website at www.health.co.st-clair.il.us . Click on the "About" tab, then find the HIPAA link listed under "Other pages of Interest". Click on "St. Clair County Health Department HIPAA Notice of Privacy Practices (read) to see the entire document.

If you do not have access to the internet, and would like a copy of this notice sent to you, please call our office at (618) 825-4408.

You may also stop by our offices at any time to read this notice.

Complete this form only if you have zero income at this time

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM
NO-INCOME AFFIDAVIT

I, _____, hereby certify the following:
Print Name

Please check all that apply:

☐ I am over the age of 18 and currently am unable to remain in my residence. I will be admitted to hospice imminently.

☐ Prior to my cancer diagnosis, I earned approximately $_____/year.

☐ I currently do not earn, and do not expect to earn over the next twelve months, income from any employer; and I do not receive any supplemental income from any public or private sources; and

☐ I do not receive any ongoing payments from rents, royalties, recurring gifts, hobby income, insurance payments, disability or unemployment benefits, retirement income, investment income; etc.

This affidavit is made under penalty of perjury. Any fraudulent or untrue Statements made in this affidavit will result in denial of Health Benefits for Persons with Breast or Cervical Cancer and/or possible legal action.

Signature _____ Date: _____

Witness to Signature: _____ Date: _____