



BREAST AND CERVICAL CANCER PROGRAM

ENROLLMENT PACKET

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, 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. Please do not make your own appointments. We will only pay for those appointments that are made by our staff. We are very limited in the services we can pay for, and do not want you to get charged for unexpected services. Our staff will call you with your appointment dates and times. You will also receive an appointment sheet detailing your appointments as well.

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

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 items 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
- Breast Cancer Risk Tool
Complete to the best of your knowledge

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

- Income Verification
(2 most recent paycheck stubs 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



BREAST AND CERVICAL CANCER PROGRAM

ELIGIBILITY DETERMINATION FORM (1/2)

Shaded areas are for IBCCP office use only

<input type="radio"/> New Client Registration Date _____		<input type="radio"/> Established Client Annual Date _____		<input type="radio"/> 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) <input type="checkbox"/> Medicare Part B - Not eligible for IBCCP <input type="checkbox"/> Medicaid ID number _____ <input type="checkbox"/> I DO NOT have insurance <input type="checkbox"/> I have Insurance Carrier _____ <input type="checkbox"/> I am covered under a parent or spouse insurance Insurer Name _____ Does Insurance pay for: Pap tests <input type="radio"/> No <input type="radio"/> Yes Mammograms <input type="radio"/> No <input type="radio"/> Yes Do you have a deductible that must be met before diagnostic procedures are covered? <input type="radio"/> No <input type="radio"/> Yes <i>Please provide a copy of the front and back of your Insurance Card</i>			
Employment Status <input type="radio"/> Employed Full-Time (35+ hours wkly) (EFT) <input type="radio"/> Employed Part-Time (EPT) <input type="radio"/> Not in the labor force (NLF) <input type="radio"/> Seasonal / Migrant Farm Worker (SMF) <input type="radio"/> Self-employed (SE) <input type="radio"/> Temporary Worker (TW) <input type="radio"/> Unemployed (UNE) Marital Status <input type="radio"/> Never Married (01) <input type="radio"/> Married (02) <input type="radio"/> Other: _____ Years of Education Completed <input type="radio"/> _____ (EO # of years) <input type="radio"/> Unknown (E099)				Income determination Total income before taxes (if married, total combined income before taxes) \$ _____ per month / year (circle one) Number of people under age 18, your spouse (if applicable) and yourself, who are supported by this income _____			
				Income status for # in household <input type="radio"/> At or below 250% of federal poverty level <input type="radio"/> Above 250% of federal poverty level			



BREAST AND CERVICAL CANCER PROGRAM

ELIGIBILITY DETERMINATION FORM (2/2)

Are you of Hispanic or Latino Origin?

Yes No

Preferred language for delivery of service

English (E) Spanish (S) Other (O) _____

What races do you consider yourself? (check all that apply)

- | | | | | |
|---|---|-----------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American | | | |
| <input type="checkbox"/> Native Hawaiian / Other Pacific Islander | <input type="checkbox"/> American Indian / Alaskan Native | | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Vietnamese |
| | <input type="checkbox"/> Korean | <input type="checkbox"/> Filipino | <input type="checkbox"/> Other _____ | |

How did you hear about this program?

- | | |
|--|---|
| <input type="radio"/> Poster (PO) | <input type="radio"/> Newspaper (ME) |
| <input type="radio"/> Flier (FL) | <input type="radio"/> Radio (ME) |
| <input type="radio"/> Brochure (BR) | <input type="radio"/> Television (ME) |
| <input type="radio"/> Community Navigator (C) | <input type="radio"/> Website (Agency/State)(WB) |
| <input type="radio"/> Community Event (CE) | <input type="radio"/> Other (OTH), Specify _____ |
| <input type="radio"/> Physician or Health Care Provider (P) Name _____ Phone # _____ | |

Barriers

- | | | |
|---|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Financial | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Need Interpreter | <input type="checkbox"/> Child / Family Care | <input type="checkbox"/> Travel Distance |
| <input type="checkbox"/> Work Schedule | <input type="checkbox"/> Making Appointments | <input type="checkbox"/> Understanding Medical Needs |
| <input type="checkbox"/> Special Needs | <input type="checkbox"/> Other: _____ | |

What Is the best day to schedule your appointments?

Monday Tuesday Wednesday Thursday Friday

What Is the best time to schedule your appointments?

Early-Morning Mid-Morning Early-Afternoon Late-Afternoon

Preferred Healthcare Provider _____

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

Applicant Signature: _____ **Date:** _____

BREAST AND CERVICAL CANCER PROGRAM

IBCCP HEALTH ASSESSMENT (1/1)

Shaded areas are for IBCCP office use only

Name _____		Date _____	
Yes	No	Breast Health Questions	Yes No Cervical Health Questions
<input type="radio"/>	<input type="radio"/>	1. Do you routinely check your breasts for changes?	<input type="radio"/> <input type="radio"/> 13. Have you ever had a Pap test?
<input type="radio"/>	<input type="radio"/>	2. Have you noticed a lump in your breasts? IF YES Which breast? <input type="radio"/> Right <input type="radio"/> Left	<input type="radio"/> <input type="radio"/> Provider where test was done _____
<input type="radio"/>	<input type="radio"/>	3. Have you noticed any breast tenderness or pain? IF YES Did the breast tenderness or pain increase around the time of your menstrual period? <input type="radio"/> Yes <input type="radio"/> No Which breast? <input type="radio"/> Right <input type="radio"/> Left	<input type="radio"/> <input type="radio"/> IF YES Date of last Pap test (before this visit) _____
<input type="radio"/>	<input type="radio"/>	4. Have you noticed spontaneous discharge (not from stimulation or squeezing) your nipples? IF YES Which breast? <input type="radio"/> Right <input type="radio"/> Left	<input type="radio"/> <input type="radio"/> If date unknown, was it more than 10 years ago? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/>	<input type="radio"/>	5. Have you noticed any other symptoms related to your breasts? IF YES Explain _____	<input type="radio"/> <input type="radio"/> Were your last test results normal? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/>	<input type="radio"/>	6. Have you ever had a breast exam done by a doctor or nurse? IF YES Provider / clinic where breast exam was done _____ Date of last exam (before this current visit) _____	<input type="radio"/> <input type="radio"/> 14. Date of your last menstrual period _____
<input type="radio"/>	<input type="radio"/>	7. Have you ever had a mammogram? IF YES Provider / clinic where mammogram was done _____ Date of your last mammogram (before this current visit) _____ If unknown was it over 5 years? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> <input type="radio"/> 15. Are you pregnant?
<input type="radio"/>	<input type="radio"/>	8. Have you ever had breast cancer?	<input type="radio"/> <input type="radio"/> 16. Have you had a hysterectomy? IF YES Was your cervix removed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<input type="radio"/>	<input type="radio"/>	9. Has your mother, father, sibling, (sister / brother), daughter or son had breast cancer? IF YES Who _____ Are they BRCA positive? (if unknown leave blank) <input type="radio"/> Yes <input type="radio"/> No At what age? _____	<input type="radio"/> <input type="radio"/> Was it due to a past history of cervical disease or cervical cancer? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/>	<input type="radio"/>	10. Do you have a breast implant or implants?	<input type="radio"/> <input type="radio"/> 17. Were you exposed to Diethylstilbestrol (DES)?
<input type="radio"/>	<input type="radio"/>	11. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast? IF YES Which breast? <input type="radio"/> Right <input type="radio"/> Left Provider who performed the procedure _____	<input type="radio"/> <input type="radio"/> 18. Is your immune system weakened in any way? (medication, HIV, organ transplant or other health condition)
<input type="radio"/>	<input type="radio"/>	12. Have you ever had radiation to the chest area?	Yes No Tobacco Questions
			<input type="radio"/> <input type="radio"/> 19. Do you smoke cigarettes? IF YES Are you ready to quit smoking? <input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> <input type="radio"/> Are you interested in being referred to the Illinois Tobacco Quitline? <input type="radio"/> Yes <input type="radio"/> No
			20. Date referral sent to Tobacco Quitline _____
			Risk Assessment Questions Breast & Cervical Cancer Risk (from Summary Office Visit form)
			21. Lifetime risk for breast cancer _____
			22. Is client high risk for breast cancer? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
			23. Is client high risk for cervical cancer? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown



BREAST AND CERVICAL CANCER PROGRAM

STATE OF ILLINOIS CORNERSTONE INFORMED CONSENT FORM (1/1)

Name of Participant

Last Name	First Name	Middle Initial
/ /	<input type="radio"/> Male <input type="radio"/> Female	
Date of Birth (Month/Day/Year)	Participant's 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 evolution purposes. Necessary information, without any client's name, will be sent to federal agencies that fund these programs.

- 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 development 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 / facsimile of this consent will be as valid as the original

For Child Participant

For Adult Participant

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



BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION (1/2)

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 screenings and provides free screenings and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screenings 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 precancerous 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).

(cont. next page)



BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION (2/2)

- 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.

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



BREAST AND CERVICAL CANCER PROGRAM

REQUEST FOR CONFIDENTIAL COMMUNICATIONS (1/1)

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	/ /
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BREAST AND CERVICAL CANCER PROGRAM

NOTICE OF PRIVACY PRACTICES (1/1)

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.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Shaded areas are for IBCCP office use only

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

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

Efforts to Obtain _____

Reason patient refused to sign _____

_____	/	/	_____
Employee Signature			Date



BREAST AND CERVICAL CANCER PROGRAM

AUTHORIZATION TO OBTAIN INFORMATION (1/1)

I hereby give consent to release the following information

- Client Report
- Medical Records
- 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.

	/ /
Signature	Date

	/ /
Witness Signature	Date



BREAST AND CERVICAL CANCER PROGRAM

NO-INCOME AFFIDAVIT (1/1)

Complete this form only If you have zero Income at this time

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 Signature

_____/_____/_____
Date



BREAST AND CERVICAL CANCER PROGRAM

BREAST CANCER RISK TOOL (1/1)

Name _____ Date of Birth _____

Do you have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or previous radiation therapy to the chest for treatment of Hodgkin lymphoma?

- Yes No

Do you have mutation in either the BRCA 1 or BRCA2 gene, or diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer?

- Yes No Unknown

Have you ever had a breast biopsy with a benign (not cancer) diagnosis?

- Yes No

IF YES

How many breast biopsies with a benign diagnosis have you had?

Have you ever had a biopsy with atypical hyperplasia?

- Yes No Unknown

What was your age at time of first menstrual period?

- 7 to 11 12 to 13 14 or older

What was your age when you gave birth to your first child?

- _____ years old I have never given birth

How many of your first-degree relatives (mother, sisters, daughters) have had breast cancer?

- None One More than one Unknown