



Eligibility and Enrollment Form



Eligibility Information

What is your age? ____ Family's yearly income before taxes: ____ Number of people in household: ____

Do you have Medicaid? Yes No

Do you have Medicare Part B? Yes No

Do you have health insurance that may cover these services? Yes No

Enrollment Information

Social Security Number: ____ - ____ - ____ Date of Birth: ____ / ____ / ____
Month Day Year

Name: ____ Other Last Name(s) Used: ____
Last First MI

Mailing Address: ____ Street Address: ____

City: ____ State: ____ Zip Code: ____

County of Residence: ____

Phone: Home: (____) ____ - ____ Work/Message: (____) ____ - ____

Ethnic Background: Are you Hispanic? (Spanish/Hispanic/Latino)

Yes No

Race:

Which race(s) describe(s) you best:

- White
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Unknown

Medical Background:

Are you having any breast problems? Yes No

Have you ever had a mammogram? Yes No

Date of last mammogram: ____ / ____
Month Year

Have you ever had a pap test? Yes No

Date of last pap: ____ / ____
Month Year

Have you had a hysterectomy? Yes No

How did you hear about the program? Please check all that apply.

- Radio Newspaper Pamphlet/Pink Card Special Promotion/Promotional Ad
- Fair Presentation Medical Service Provider Public Assistance Office/County Health Depart.
- TV Family/Friend Mailing Re-screen/Previously Enrolled
- Poster Other (Specify)

PLEASE READ AND SIGN THE BACK OF THIS FORM

Your signature indicates you have read and understand the MBCHP Informed Consent and Authorization to Disclose Health Care Information

Office Use Only

Site #: _____

New Screening Cycle

Revised Form

Eligibility Determined by (please print): _____ Date: ____ / ____ / ____

Client Under 50-Prior approval given by: _____ Date: ____ / ____ / ____



Please Read and Sign

Informed Consent and Authorization to Disclose Health Care Information



The Montana Breast and Cervical Health Program (MBCHP) receives funds from the Centers for Disease Control and Prevention (CDC) to provide breast and cervical cancer screenings for age and income eligible Montana women, in order to save lives by detecting cancer and pre-cancerous conditions at the earliest possible time. Each time a woman is screened for breast cancer, CDC recommends she receive a clinical breast exam and a breast X-ray called a mammogram. Each time a woman is screened for cervical cancer, CDC recommends she receive a pelvic examination and Pap test. If any of the initial tests for breast or 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. Because of CDC recommendations, women who enroll in the MBCHP must receive a mammogram, clinical breast exam, Pap test, and pelvic exam. MBCHP will provide case management service that will help you complete all the diagnostic tests and find resources that may help pay for treatment (if necessary). By enrolling in MBCHP, you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests are recommended by your medical provider.

Services Not Covered

The MBCHP 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 MBCHP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by MBCHP.

Insurance Information

I understand I have met the eligibility guidelines for MBCHP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for breast and cervical cancer screening services. If the services are not fully reimbursed by my insurance, the MBCHP 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 health care provider, and the MBCHP staff. The MBCHP staff means those personnel at the Montana Department of Public Health and Human Services, the administrative site and the tribal organization and Indian Health Service Units who are specifically designated to work in the MBCHP. Program reports will include information on groups of women 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 MBCHP staff, my health care provider(S), the laboratory reading my Pap smear, and the radiology facility where my mammogram is performed with respect to MBCHP 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 MBCHP and agree to participate in the program. I have had an opportunity to ask questions about the MBCHP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MBCHP is to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out of the MBCHP at any time.

Client Signature: _____

Date: _____

Print Client's Full Name: _____

Date: _____

Witness Signature: _____

Date: _____