MCCP Breast and Cervical Cancer
Screening Eligibility and Enrollment Form

Contact information:

First name: _____ Middle Initial: _____ Last name: _____
Birthdate: _____ Age: _____ SSN: _____
Mailing: _____ City: _____ ST & Zip: _____
Email: _____ Home: _____ Cell: _____
Aliases: _____ Gross income: _____ Household members #: _____

Race and Ethnicity: Check all that apply

☐ White ☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown
Are you Hispanic? ☐ Yes ☐ No ☐ prefer not to say

Healthcare Coverage:

Medicare Part B: ☐ Yes ☐ No Medicaid: ☐ Yes ☐ No
Private Insurance: ☐ Yes ☐ No Name: _____ Deductible or co-pay: _____

Medical Background:

Are you having Breast Problems: ☐ Yes ☐ No Have you ever had a mammogram: ☐ Yes ☐ No Date of last mammogram: _____ Do you have Breast Implants: ☐ Yes ☐ No Do you have a family history of breast cancer: ☐ Yes ☐ No ☐ Unknown	Have you ever had a Pap test: ☐ Yes ☐ No Date of last Pap test: _____ Have you had a hysterectomy: ☐ Yes ☐ No ☐ Unknown If yes, was it due to cervical cancer: ☐ Yes ☐ No ☐ Unknown If yes, do you still have a cervix: ☐ Yes ☐ No ☐ Unknown

How did you hear about us? Check all that apply

☐ TV ☐ Presentation ☐ Newspapers/Newsletters
☐ Radio ☐ Pamphlets/Flyers ☐ Job/Health Fair or Pow Wow
☐ Internet ☐ Government office ☐ Friend/Family/Word of mouth
☐ MAIWHC ☐ Previously Enrolled ☐ Special Promotion/Promotional Ad
☐ Medical Provider ☐ Other

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

Please read and sign the Informed Consent and Authorization to Disclose Health Care Information on the following page

Please Read and Sign below

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.

Type Full Name_____ Date_____

Client Signature_____