Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

APPLICATION PACKET
Client and Website Only

For questions please call:

<table>
<thead>
<tr>
<th>Regional Coordinator:</th>
<th>Leonor Marrero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counties Served by Region:</td>
<td>Osceola</td>
</tr>
<tr>
<td>Phone:</td>
<td>407-343-2068</td>
</tr>
<tr>
<td>Confidential Fax:</td>
<td>407-343-2158</td>
</tr>
</tbody>
</table>

Please use checklist below to ensure all paperwork is completed and returned with this coversheet to:

Osceola Regional FBCCEDP Office via confidential fax or mail to:

Florida Department of Health Osceola County
Florida Breast and Cervical Cancer Early Detection Program
1875 FORTUNE RD
KISSEMMEE, FL 34744

CLIENT CHECKLIST

- [ ] Annual Applicant Agreement
- [ ] Financial Eligibility Form
- [ ] Client Enrollment Form
- [ ] Initiation of Services (for County Health Departments only)
- [ ] Authorization to Disclose Confidential Information
- [ ] Your Provider’s Mammogram Order
Florida Breast and Cervical Cancer Early Detection Program
Client Enrollment Form

1. APPLICANT INFORMATION (Please complete each section of this application.)

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
<th>SCREENING STATUS (Check only one response.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STREET ADDRESS:</td>
<td>Initial (first time in program)</td>
</tr>
<tr>
<td>STREET ADDRESS:</td>
<td>Rescreen (previously in program)</td>
</tr>
<tr>
<td>CITY &amp; ZIP CODE:</td>
<td>Short-term interval follow-up or repeat exam</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td>(less than 300 days from last screening)</td>
</tr>
<tr>
<td>PRIMARY PHONE:</td>
<td>Do you have health insurance?</td>
</tr>
<tr>
<td>ALTERNATE PHONE:</td>
<td>[ ] Yes [ ] No</td>
</tr>
</tbody>
</table>

DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>RESIDENTIAL AND CITIZENSHIP STATUS (Check all that apply.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida resident [ ] U.S. Citizen [ ]</td>
</tr>
<tr>
<td>Citizen in lawful status [ ] Other [ ]</td>
</tr>
</tbody>
</table>

ETHNICITY AND RACE IDENTIFICATION (Check all that apply.)

<table>
<thead>
<tr>
<th>RACIAL IDENTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native [ ]</td>
</tr>
<tr>
<td>Asian [ ]</td>
</tr>
<tr>
<td>Black or African American [ ]</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander [ ]</td>
</tr>
<tr>
<td>White [ ]</td>
</tr>
</tbody>
</table>

SPOKEN LANGUAGE(S)

Primary language spoken: _____________________________

Additional language(s) spoken: _______________________

Language preference to receive mail: English [ ] Spanish [ ] Creole [ ]

HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)

<table>
<thead>
<tr>
<th>HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Cancer Society [ ] Postcard [ ] Television [ ]</td>
</tr>
<tr>
<td>Brochure [ ] Radio [ ] Social Media [ ] Educational Session</td>
</tr>
<tr>
<td>County Health Department [ ]</td>
</tr>
<tr>
<td>Community/Health Fair event [ ]</td>
</tr>
<tr>
<td>Family/Friend [ ] Internet/Website [ ] Bus wraps/benches/signs</td>
</tr>
<tr>
<td>Private Medical Office [ ] Billboards [ ] Name of Community Health Clinic:</td>
</tr>
<tr>
<td>Newspaper [ ] Federally Qualified Health Center [ ]</td>
</tr>
<tr>
<td>Other [ ]</td>
</tr>
</tbody>
</table>

BEST TIME TO REACH YOU:

<table>
<thead>
<tr>
<th>BEST TIME TO REACH YOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.M. [ ] P.M. [ ] Anytime</td>
</tr>
</tbody>
</table>

Is it okay to leave a message? [ ]

PREFERRED APPT. DAY/TIME:

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#: _____________________________

DOH-FBCCEDP Revision July 23, 2021
Florida Breast and Cervical Cancer Early Detection Program
Client Enrollment Form

2. HEALTH HISTORY

GENERAL HEALTH STATUS (Check all that apply.)

- Diabetes
- Pre-Diabetes
- High Blood Pressure
- High Cholesterol

HEIGHT (in.): [ ]
WEIGHT (lbs.): [ ]

Tobacco Use (includes vaping, e-cigarettes, and similar products) (Check all that apply.)

- Daily
- Some days
- Never/not at all
- Declined to answer

Were you given a referral to Quitline?

- Declined referral
- I am interested in quitting.

DOH-FBCCEDP Revision July 23, 2021

Client Assigned ID# or Pseudo SS#:

FOR OFFICE USE ONLY
Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

FINANCIAL ELIGIBILITY

Client Name: ___________________________ Date of Birth: ___________________ ID#__________________

1. Do you have Medicaid? □ YES □ NO       OR Do you have Medicare? □ YES □ NO

2. Do you have any form of health insurance? □ YES □ NO   Name of insurance ___________________________

3. Number of people in your Household. _________ (include yourself, spouse or civil union partner, and dependent children)

4. Net Household Income (After Taxes): $__________ Month OR $__________ Year

<table>
<thead>
<tr>
<th>Family Size</th>
<th>2022 DOH Scale Monthly Income</th>
<th>2022 DOH Scale Yearly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,264.91</td>
<td>$27,179.00</td>
</tr>
<tr>
<td>2</td>
<td>$3,051.58</td>
<td>$36,619.00</td>
</tr>
<tr>
<td>3</td>
<td>$3,838.25</td>
<td>$46,059.00</td>
</tr>
<tr>
<td>4</td>
<td>$4,624.91</td>
<td>$55,499.00</td>
</tr>
<tr>
<td>5</td>
<td>$5,411.58</td>
<td>$64,939.00</td>
</tr>
<tr>
<td>6</td>
<td>$6,198.25</td>
<td>$74,379.00</td>
</tr>
<tr>
<td>7</td>
<td>$6,984.91</td>
<td>$83,819.00</td>
</tr>
<tr>
<td>8</td>
<td>$7,771.58</td>
<td>$93,259.00</td>
</tr>
<tr>
<td>9</td>
<td>$8,558.25</td>
<td>$102,699.00</td>
</tr>
<tr>
<td>10</td>
<td>$9,344.91</td>
<td>$112,139.00</td>
</tr>
</tbody>
</table>

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:
If I obtain health insurance coverage, while under the FBCCEDP, it is my responsibility to notify the REGIONAL FBCCEDP office as soon as possible.

Signature___________________________________________

Date ______________________________________________

If you have any questions, please call the regional coordinator at _____________________________ between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.
Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

The Annual Applicant Agreement (AAA) is used to obtain authorization and information from eligible women enrolled in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). The FBCCEDP will collect participant Protected Health Information (PHI) and Personally Identifiable Information (PII) that is required to provide patient services.

Please read each statement below and agree by signing at the bottom of the document.

As an FBCCEDP applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCCEDP, and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level (FPL) and I have no health insurance that pays for breast and cervical cancer screening exams.
3. I will no longer be eligible for FBCCEDP if my income changes to above 200% of the FPL.
4. I will call FBCCEDP Once I obtain health insurance and give them the name of the health insurance company, policy number and effective date. If my health insurance covers breast and cervical cancer screenings my screenings will no longer be paid for by FBCCEDP.
5. I will disclose any breast or cervical screening services that may impact my eligibility of enrollment in FBCCEDP.
6. I may have a share of cost for some services.
7. I will use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test).
8. I agree to complete any follow-up tests within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.
9. I will allow an exchange and release of my medical information between my health care providers, the FBCCEDP, the Florida Department of Health's Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination and procedure results, even if they were not paid by FBCCEDP.
10. I agree to receive home phone, cellphone, email or postal mail contact from FBCCEDP and the Department of Children and Families (DCF) Medicaid Program about my health care.
11. I understand that the FBCCEDP is a breast and cervical cancer screening program, not a cancer treatment program.
12. If I am diagnosed with breast or cervical cancer as a result of FBCCEDP screening, I will be referred to DCF Medicaid Program which will determine if I am eligible for Medicaid benefits to cover treatment cost. I can reapply to FBCCEDP for screenings once treatment is completed.
13. This agreement is for one year unless my program eligibility changes. If my eligibility status changes or this agreement expires, I may be responsible for services provided during my FBCCEDP ineligible period.
14. As authorized by federal law, Title 5 U.S. Code section 552a, collection of social security numbers by the Florida Department of Health for the FBCCEDP may be necessary in order to apply for and receive Medicaid benefits.

If you have any questions, contact your Regional Coordinator at the local Regional FBCCEDP office:

Local Regional FBCCEDP: Osceola Phone #: 407-343-2068

Client Signature ___________________________ Date __________

Printed Name ___________________________ Date of Birth __________

Client Email Address: ___________________________

DOH- FBCCEDP July 1, 2021
AUTHORIZED TO DISCLOSE
CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:
Person/Facility: FBCCP Osceola - Florida Dept. of Health in Osceola County
Address: 1875 FORTUNE ROAD KISSIMMEE, FL 34743
Phone #: 407-343-2068
Fax #: 407-343-2158

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _______________________ Phone #: ___________________

METHOD OF DISCLOSURE:

___ Pick up at Clinic/Facility

___ Address: ______________________________

___ Fax #: ________________________________

___ Email Address: (please note that emailing may not be a secured method of communication)

INFORMATION TO BE DISCLOSED: (Initial Selection)

X General Medical Record(s) ___ STD Records ___ TB Records ___ History and Physical Results

___ Immunizations ___ Family Planning ___ Prenatal Records ___ Consultations

___ Progress Notes

X Diagnostic Test Reports (Specify Type of test(s)) MAMMOGRAMS, BT U/S AND BIOPSY TEST RESULTS

___ Other: (specify) __________________________

I specifically authorize release of information relating to: (initial selection)

___ HIV test results ___ Substance Abuse Service Provider Client Records

___ Psychiatric, Psychological or Psychotherapeutic notes ___ Early Intervention ___ WIC

PURPOSE OF DISCLOSURE:

X Continuity of Care ___ Personal Use ___ Other (specify)

EXPIRATION DATE: This authorization will expire (insert date or event) ________________. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCAUTION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

X Client/Legal Representative Signature

X Date

SELF

Printed Name

Legal Representative’s Relationship to Client

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).

Client Name: ____________________________

ID#: ______________________

DOB: ______________________

Original: To File Copy: To Client Copy: To Accompany Disclosure