FBCCEDP Eligibility

Eligibility for Breast and Cervical Cancer Screening:
- Female, age 50 to 64
- Resident of Florida
- No insurance, Under Insured, or medically needy
- Income at or below 200% of federal poverty guidelines
- Not screened within the prior year.
- Any woman under age 50 or over age 64 (up to age 74), suspicious for breast cancer (breast symptoms/CBE) may be eligible.
- Women 40-49 who are not suspicious for breast cancer with family history (parent, sister, brother, or child) with breast cancer may be eligible.
- Women of any age who have completed treatment for breast cancer may be eligible.

To apply, please contact the Florida Department of Health, Participating Medical Group Nearest you or Call the number listed below for more information.

Each application will be reviewed by program staff or manager for eligibility. On approval, a voucher will be issued to the primary provider to schedule the next available appointments for eligible services. Women may enroll at any Florida Department of Health or participating medical group within the regional area. (Please see Region listed below).

Referrals for further diagnostics and services will be made by primary provider per authorization for reimbursement from the regional office.

"Application for Medicaid Breast and Cervical Treatment Act, for available funds, to be completed by program manager and medical/imaging facility assistance". Medicaid application to be submitted with a BI-RADS report of 4 and above. DCF will update information, when pathology report confirms cancer diagnosis, is received.
Florida Breast and Cervical Cancer Early Detection Program
Annual Applicant Agreement

Please read each statement and sign at the bottom of the page.

I declare that:

1. I want to become a client of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level 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 Federal Poverty Level.
4. I will call FBCCEDP once I enroll into 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 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 test 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 phone or 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 who will determine if I am eligible for Medicaid 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 FBCEEDP ineligible period.

__________________________  _________________________
Client signature           Date

__________________________  _________________________
Printed name               Date of birth

Revised June 2019
The Florida Department of Health in Putnam County Invites you to take part in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). If you qualify, you may receive your breast and Cervical cancer examinations free. If your test results are not normal, FBCCEDP will work with your medical team to obtain additional tests and if needed, treatment.

If you have an abnormal result and need diagnostics or treatment, There may be some cost to you for tests. Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties

All fields MUST BE COMPLETED for application to be processed.

Identification/General Information

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<th>Date of Birth:</th>
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Mailing ADDRESS:

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<th>Race:</th>
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<td>American Indian or Alaskan Native</td>
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<td>Asian</td>
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<td>Native Hawaiian or Pacific Islander</td>
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<th>Ethnicity:</th>
<th>Are you Hispanic or Latino?</th>
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<td>Yes</td>
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VOUCHER ISSUED: ______________
FILL THIS SECTION OUT

Primary Care Physician(preferred):

Imaging Center(preferred):

Height: ____________ (In Inches i.e. 60”)

Weight: ____________ lbs.

BP: ____________

Diabetes: ○ Yes Type: ________ ○ No

Pre-Diabetic: ○ Yes ○ No

Hx of hypertension or High Blood Pressure: ○ Yes ○ No

Exercise 5x weekly ○ Yes ○ No

High Blood Cholesterol: ○ Yes ○ No

Eat 5 servings fruits/vegetables daily? ○ Yes ○ No

Tobacco Use: ○ Daily ○ Somedays ○ Not at all ○ Former ○ Declined to answer

Would you like to ENROLL in our FREE SMOKING CESSATION PROGRAM? ○ Yes ○ No

Income/Insurance Information: REQUIRED INFORMATION FILL OUT COMPLETELY

Do you HAVE any health insurance? ○ Yes ○ No

Are you receiving:

Medicaid ○ Yes ○ No

Medicare A ○ Yes ○ No

Medicare B ○ Yes ○ No

1. Number in Household: ____________________________

2. Monthly Income: ____________________________

3. Annual Income: ____________________________

4. Unemployment: ____________________________

Client Agreement

○ I understand that no test is 100% accurate.

○ This statement is true at the time it is made. I understand that the provider shall attempt to verify the statement. Verification can be secured by telephone, in written form, or face to face contact: verification does not require a written document to confirm an applicant or client’s statement. If the provider is unable to verify wages paid or an employer will not verify wages paid, the signed self-declaration provided by the applicant must be accepted as accurate.

○ I have read or had the above read to me. I agree that the information have provided is correct.

Client signature: ____________________________ Date: ____________________________

Please Print Name: ____________________________

Referred by: ____________________________

PLEASE ATTACH ANNUAL APPLICATION AGREEMENT AND AUTHORIZATION FORM SIGNED AND DATED.

THANK YOU

Do you need transportation to and from appointments? ○ Yes ○ No

VOUCHER ISSUED: ______________
AUTHORIZATION TO DISCLOSE
CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:
Person/Facility: ___________________________ Phone #: ___________________________
Address: _______________________________________________________________________

INFORMATION MAY BE DISCLOSED TO:
Person/Facility: Florida Department of Health in Putnam County / FBCCEDP Phone #(386) 326-3200 or (386) 326-3281
METHOD OF DISCLOSURE:
_____ Pick up at Clinic/Facility
_____ Address: 2801 Kennedy Street, Palatka, Florida 32177
_____ Fax #: e-fax # (386) 643-6677
_____ Email Address: (please note that emailing may not be a secured method of communication)

FBCCED Program @ Florida Department of Health in Putnam County direct line (386) 326-3281

INFORMATION TO BE DISCLOSED: (Initial Selection) (by the X)

_____ General Medical Record(s) _____ STD Records _____ TB Records _____ History and Physical Results
_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

X _____ Progress Notes
X _____ Diagnostic Test Reports (Specify Type of test(s)) All breast and cervical screening, diagnostics, imaging and labs.
X _____ Other: (specify) Consent to fax enrollment & results to FBCCEDP/CDC/Florida Department of Health in Putnam County and Central office (Tallahassee, Florida). (Consent to contact by phone or mail)

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 X _____ Personal Use Other (specify) Provider Reimbursement & Management by FBCCED Program

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.

REDISCLOSURE: 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.

Client/Legal Representative Signature ___________________________ Date ___________
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 of 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