Florida HEALTH
Putnam County

Florida Breast & Cervical Cancer Early Detection Program

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* 50 or *over* 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 manager or staff 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". Tentative Medicaid application to be submitted with BI-RADS report of 4 and above. DCF will update information, when pathology report confirms cancer diagnosis, is received.

Clinical Breast Exam

- Pap (Age 50 and above, without a hysterectomy)
- Screening mammogram
- Diagnostic imaging
- Biopsy Assistance
- Medicaid application with cancer diagnosis

FBCCEDP/FDHCP
Regional Site Office
2801 Kennedy Street
Palatka, Florida 32177
Phone: 386-326-3281
E-Fax: 386-643-6677

"Free or low cost mammograms offered to eligible women by the Florida Breast and Cervical Cancer Early Detection Program".

Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwanee, Union and surrounding counties

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: PUTNAM Phone #: (386) 326-3281

Client Signature _____ Date _____

Printed Name _____ Date of Birth _____

Client Email Address: _____

Florida HEALTH Putnam County

FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION SCREENING PROGRAM Putnam County

PATIENT ENROLLMENT REFERRAL FORM (PRF)

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

NAME:

Last First Middle Name Maiden Name

Date of Birth: **Age**:

PHONE: **Other PHONE:**

Mailing ADDRESS:

Street/P.O. Box City Zip County

(If different from above)

Street ADDRESS:

Street City Zip County

BREAST EXAM BACKGROUND: FILL OUT COMPLETELY

- Have you yourself been diagnosed with breast cancer? ◯Yes Year(when?):_____ ◯No
- Family Hx of breast cancer? ◯Yes ◯No: Circle who: Primary: Mother/Father/Sibling/Child 2nd: Grandmother, Aunt, Cousin.
- Do you have implants? ◯Yes How long? ◯No
- Have you ever had a Mammogram? ◯Yes ◯No
- If YES: Where (provider)? _____When? Month/Year:_____ ◯Unsure (5+years)

Cervical Exam Background: FILL OUT COMPLETELY

- Have you yourself ever been diagnosed with cervical cancer? ◯Yes Year(when?)_____ ◯No
- HYSTERECTOMY: ◯Yes ◯No
- If YES: ◯FULL or ◯PARTIAL Do you have your Cervix? ◯Yes ◯No
- Have you ever had a PAP SMEAR exam? ◯ Yes ◯ No
- If YES: Where (provider)?_____When? Month/Year:_____◯Unsure (5+years)

Program Data

Race: Check all that apply

◯**American Indian or Alaskan Native** ◯**Black/African American** ◯**White**
◯**Asian**
◯**Native Hawaiian or Pacific Islander** ◯**Other, Please specify**:_____

Primary Language: ◯ English ◯Spanish

Ethnicity: Are you Hispanic or Latino? ◯ Yes ◯ No

VOUCHER ISSUED:_____

Florida HEALTH
Putnam County

FILL THIS SECTION OUT

Primary Care Physician(preferred):

Imaging Center(preferred):

Height:_____ **inches** 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 "Net" Income:**_____**(Net – After All Bills Are Paid)**
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 FORM **SIGNED AND DATED**. THANK YOU

Do you need transportation to and from appointments? ◯**Yes** ◯**No**
Please check with your local resources.

VOUCHER ISSUED:_____

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

Family Size	2021 DOH Scale Monthly Income	2021 DOH Scale Yearly Income
1	$2,146.58	$25,759.00
2	$2,903.25	$34,839.00
3	$3,659.91	$43,919.00
4	$4,416.58	$52,999.00
5	$5,173.25	$62,079.00
6	$5,929.91	$71,159.00
7	$6,686.58	$80,239.00
8	$7,443.25	$89,319.00
9	$8,199.91	$98,399.00
10	$8,956.58	$107,479.00

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 (386) 326-3281 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.

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 Putnam County / FBCCEDP Phone #:(386) 326-3281 / (386) 326-3200

METHOD OF DISCLOSURE

_____ Pick up at Clinic / Facility

_____Address: 2801 Kennedy Street, Palatka Florida 32177 E-Fax # (386) 643-6677

_____Email Address: (Please note that emailing may not be a secured method of communication)
FBCCEDP Program @ Florida Department of Health in Putnam County direct line (386) 326-3281

INFORMATION TO BE DISCLOSED: (Initial Selection, By the X; If, not initialed your signature, will determine approval)

_____ General Medical Record(s), including STD and TB **X**_____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records **X**____ Consultations

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 email)

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

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

X____ Continuity of Care _____ Personal Use **X** _____ Other (specify)Provider Reimbursement & Management by FBCCEDP 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.

REVOCATION: 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/Representative Signature Date

_____ _____
Printed Name Representative's Relationship to Client

_____ _____
Witness (optional) Date

Client Name: _____

ID#: _____

DOB: _____

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

Health Care Provider Referral Form to Tobacco Free Florida

Tobacco Free Florida's Provider Referral Form Use Instructions

I. Provider Information (Required) *Provider fills out. Select Hospital or Non-Hospital. See examples on back.*

☐ **HOSPITAL** ☒ **NON-HOSPITAL**

Health System: _____ Umbrella Organization: FDOH – Putnam County

Hospital Name: _____ Clinic/Agency: FBCCEDP

Department: _____ Dept/Location: Palatka, FL

Provider Name: Provider Name:

Main Contact Person: Laurene Byers or Rita J. Cianfrocco Email: Rita.Cianfrocco@flhealth.gov and Laurene.Byers@flhealth.gov

Phone: (386) 326-3281 or 3278 Fax: (386) 643-6677

Address: 2801 KENNEDY STREET City: PALATKA State: FL Zip Code: 32177

I am a HIPAA Covered Entity and I want a feedback report: ☒ Yes ☐ No

II. Patient Information (Required) *Patient fills out*

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Email: _____

Best Phone Number: _____ Alternate Phone Number: _____

The best time to call you: *(check one)*

☐ Morning: 8am – Noon ☐ Afternoon: Noon – 5pm ☐ Evening: 5 – 9pm ☐ Anytime

Can we leave a voicemail? *(check one)*

☐ Yes ☐ No

My signature gives permission for my provider to send this form to a Tobacco Free Florida representative. I understand that I will be contacted within the next week.

Patient Signature: _____ Date: _____

Program Choice: *Check **ONE** box below (see program descriptions on back). The provider will then submit this form via fax or email to the program listed below.*

☐ Attend an in-person group or virtual class ***Fax:*** *1-888-975-1534* | ***Email:*** *tobacco@ahec.ufl.edu*

☐ Talk to a Quit Coach® over the phone ***Fax:*** *1-866-688-7577* | ***Email:*** *supportservices@optum.com*

Health Care Provider Referral Form to Tobacco Free Florida

Tobacco Free Florida's Provider Referral Form Use Instructions

Referral Form Submission Instructions

I. Provider Information: The provider completes this section. Examples are listed below:

Hospitals	Example 1	Example 2	Example 3
Health System:	UF Health	Memorial Healthcare System	Flagler Health
Hospital Name:	Shands Hospital	Memorial Hospital Pembroke	Flagler Hospital
Department:	Internal Medicine	Respiratory Therapy	Cardiopulmonary
Provider Name:	John Doe		Jane Smith
Non-hospitals	**Example 1**	**Example 2**	**Example 3**
Umbrella Organization:	Walgreens		
Clinic/Agency:	Walgreens	Santa Rosa County Health	Juan Pérez, D.O.
Dept/Location:	#1234		
Provider Name:	John Doe	Jane Doe	Juan Pérez, D.O.

II. Patient Information: The patient provides their contact information.

***Program Choice*:** Patient should select ONE program from the list.

- Provider should fax or email completed forms to the program the patient has selected.
- If the referral is sent to the in-person group or virtual class, the patient will be called by the Florida Area Health Education Center (AHEC) that serves the patient's county to schedule them in a course.
- If the referral is sent to the telephone program, a tobacco Quit Coach will call the patient to enroll them in their preferred program.

Tobacco Free Florida Program Options

Group (Virtual) Quit

Register for a session with trained facilitators along with others who want to quit like you.

- Led by a trained specialist
- 2 to 4 weeks nicotine patches, gum or lozenges
- Convenient times & locations
- Group support

Phone Quit

A Quit Coach® is waiting for your call to help you on your journey to be tobacco free.

- Quit Coach® 24/7
- 2 weeks nicotine patches or gum
- Custom plan
- 3 calls from Quit Coach®
- 1-877-U-CAN-NOW (1-877-822-6669)

Need more information about the programs available? Visit: https://tobaccofreeflorida.com/how-to-quit-tobacco/smoking-cessation-programs