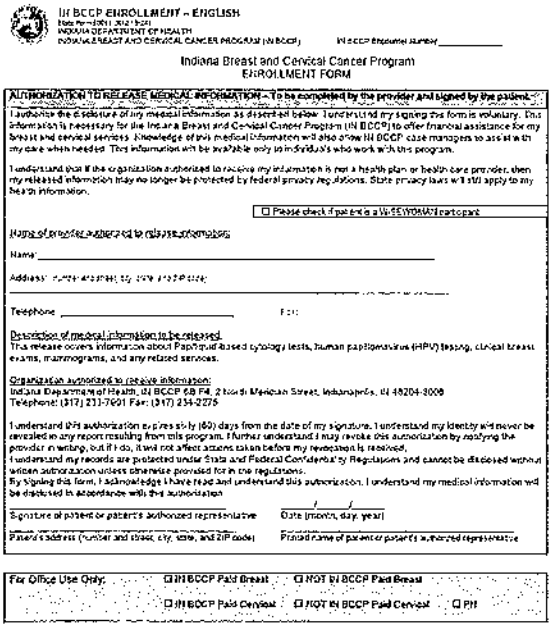
BCCP Enrollment Forms

An enrollment form must be completed the day they are enrolled in BCCP. The signature is good for 60 days, so it is best not to complete them early. We do not need a copy of the signatures, only the notification on the Eligibility page in Med-IT, along with the date that it was done. If the signature expires, simply have them sign a new one and update the page with the new date. You will keep the signature on file for the patient as the enrollment site.

The Medical Release and Program Enrollment form look like the images below. Each site has its own. They come in English and Spanish. Please email Ldietz@uhs-in.org or Jtompkins@uhs-in.org for your form with the information on your site completed.



IN BCCP ENROLLMENT – ENGLISH

Indiana Breast and Cervical Cancer Program
ENROLLMENT FORM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION – To be completed by the provider and signed by the patient.

I authorize the disclosure of my medical information as described below. I understand my signing this form is voluntary. This information is necessary for the Indiana Breast and Cervical Cancer Program (IN BCCP) to offer financial assistance for my breast and cervical services. Knowledge of this medical information will also allow IN BCCP case managers to assist with my care when needed. This information will be available only to individuals who work with this program.

I understand that if the organization authorized to receive my information is not a health plan or health care provider, then my released information may no longer be protected by federal privacy regulations. State privacy laws will still apply to my health information.

☐ Please check if patient is a VA/DEW/AM participant

Name of provider authorized to release information:

Name: _____

Address: _____

Telephone _____ Fax: _____

Description of medical information to be released:
This release covers information about Pap/liquid-based cytology tests, human papillomavirus (HPV) testing, clinical breast exams, mammograms, and any related services.

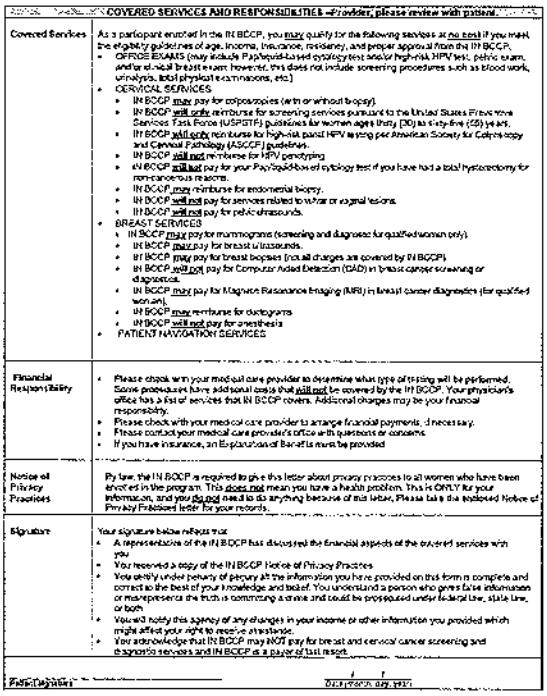
Organization authorized to receive information:
Indiana Department of Health, IN BCCP, 8B P4, 2 North Meridian Street, Indianapolis, IN 46204-3006
Telephone: (317) 233-7601 Fax: (317) 234-2275

I understand this authorization expires sixty (60) days from the date of my signature. I understand my identity will never be revealed in any report resulting from this program. I further understand I may revoke this authorization by notifying the provider in writing, but if I do, it will not affect actions taken before my revocation is received.
I understand my records are protected under State and Federal Confidentiality Regulations and cannot be disclosed without written authorization unless otherwise provided for in the regulations.
By signing this form, I acknowledge I have read and understand this authorization. I understand my medical information will be disclosed in accordance with this authorization.

Signature of patient or patient's authorized representative _____ Date (month, day, year) ____/____/____

Patient's address (number and street, city, state, and ZIP code) _____ Printed name of patient or patient's authorized representative _____

For Office Use Only: ☐ IN BCCP Paid Breast ☐ NOT IN BCCP Paid Breast
☐ IN BCCP Paid Cervical ☐ NOT IN BCCP Paid Cervical ☐ PH



COVERED SERVICES AND RESPONSIBILITIES – Provider, please review with patient.

Covered Services

As a participant enrolled in the IN BCCP, you may qualify for the following services at no cost if you meet the eligibility guidelines of age, income, insurance, residency, and proper approval from the IN BCCP.

- OFFICE EXAMS (may include Pap/liquid-based cytology test and/or high-risk HPV test, pelvic exam, and/or clinical breast exam; however, this does not include screening procedures such as blood work, urinalysis, lab/physical examinations, etc.)
- CERVICAL SERVICES
  - IN BCCP may pay for colposcopies (with or without biopsy).
  - IN BCCP will only reimburse for screening services pursuant to the United States Preventive Services Task Force (USPSTF) guidelines for women ages thirty (30) to sixty-five (65) years.
  - IN BCCP will only reimburse for high-risk panel HPV testing per American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines.
  - IN BCCP will not reimburse for HPV genotyping.
  - IN BCCP will not pay for your Pap/liquid-based cytology test if you have had a total hysterectomy for non-cancerous reasons.
  - IN BCCP may reimburse for endometrial biopsy.
  - IN BCCP will not pay for services related to vulvar or vaginal lesions.
  - IN BCCP will not pay for pelvic ultrasounds.
- BREAST SERVICES
  - IN BCCP may pay for mammograms (screening and diagnostic for qualified women only).
  - IN BCCP may pay for breast ultrasounds.
  - IN BCCP may pay for breast biopsies (not all charges are covered by IN BCCP).
  - IN BCCP will not pay for Computer Aided Detection (CAD) in breast cancer screening or diagnostics.
  - IN BCCP may pay for Magnetic Resonance Imaging (MRI) in breast cancer diagnostics (for qualified women).
  - IN BCCP may reimburse for duplograms.
  - IN BCCP will not pay for anesthesia.
- PATIENT NAVIGATION SERVICES

Financial Responsibility

- Please check with your medical care provider to determine what type of testing will be performed. Some procedures have additional costs that will not be covered by the IN BCCP. Your physician's office has a list of services that IN BCCP covers. Additional charges may be your financial responsibility.
- Please check with your medical care provider to arrange financial payments, if necessary.
- Please contact your medical care provider's office with questions or concerns.
- If you have insurance, an Explanation of Benefits must be provided.

Notice of Privacy Practices

By law, the IN BCCP is required to give this letter about privacy practices to all women who have been enrolled in the program. This does not mean you have a health problem. This is ONLY for your information, and you do not need to do anything because of this letter. Please take the enclosed Notice of Privacy Practices letter for your records.

Signature

Your signature below reflects that:

- A representative of the IN BCCP has discussed the financial aspects of the covered services with you.
- You received a copy of the IN BCCP Notice of Privacy Practices.
- You certify under penalty of perjury all the information you have provided on this form is complete and correct to the best of your knowledge and belief. You understand a person who gives false information or misrepresents the truth is committing a crime and could be prosecuted under federal law, state law, or both.
- You will notify this agency of any changes in your income or other information you provided which might affect your right to receive assistance.
- You acknowledge that IN BCCP may NOT pay for breast and cervical cancer screening and diagnostic services and IN BCCP is a payer of last resort.

Patient Signature _____ Date (month, day, year) ____/____/____

Both pages need to be signed by the patient at the time of enrollment.

There are two tools you can use for Client Information, Health History and the BCCP services which occurred. They are not required but are easy to use to collect all the required data for the program.

BCCP Indiana Client Information and Eligibility Collection

Date Completed (Validation Date): _____

PERSONAL DATA: To be completed by the patient

Name (last, first, MI): _____

Date of birth: ____/____/____ (month, day, year) Last 4 digits of Social Security number: ____ ____ ____ ____ (optional)

Street address: _____ Apt. _____

City: _____ State: _____ ZIP code: _____

County: _____ Main telephone: (____)_____ Phone Type: _____

What is your race/ethnicity? (Check ALL that apply.)

- [1] White
- [1] White - Hispanic
- [2] Black or African American
- [2] Black – Hispanic
- [3] Asian
- [3] Asian – Hispanic
- [4] Native Hawaiian or Other Pacific Islander
- [4] Native Hawaiian or Other Pacific Islander - Hispanic
- [5] American Indian or Alaskan Native
- [5] American Indian or Alaskan Native - Hispanic
- ☐ Not listed or unknown

What is the primary language spoken in your home?

- [1] English
- [2] Spanish
- [3] Arabic
- [5] French
- [13] Creole
- [6] Italian
- [9] Polish
- [14] Portuguese
- [10] Russian
- [4] Chinese
- [7] Japanese
- [8] Korean
- [12] Vietnamese
- [15] Hmong
- [11] Tagalog
- [16] Other language: _____

Translator Needed? ○ Yes ○ No

INCOME ELIGIBILITY: To be completed by the patient
The following questions determine your financial eligibility.

NOTE: If you farm or are self-employed, use net income (after subtracting business expenses).

1. Total income (earned or received by you and/or your spouse) in the last month before taxes. (Record $0 only if NO INCOME.) $ _____ per month*

2. Number of people (including yourself) who are supported by this income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more

3. Do you have insurance? ☐ Yes ☐ No

4. If yes, what is your health insurance plan?
   - ☐ Indiana Health Coverage – HIP
   - ☐ Indiana Health Coverage – Medicaid
   - ☐ Marketplace insurance
   - ☐ Employer provided (self or spouse)
   - ☐ Medicare Part A only
   - ☐ Medicare Part A and B
   - ☐ Medicaid Emergency only
   - ☐ None of the above

Provider Notes:

If you completed this for the patient in the last 60 days, you do not have to redo this page.

You do not have to collect backup for the information above.

Data Entry Note: Last grade completed is for WISEWOMAN only.

Health History: BCCP Indiana **Med-IT ID: _____**

Only do Health History if new to BCCP, had a new history of breast or cervical cancer, a hysterectomy, if you gave out smoking cessation information, or she is now high-risk.

CERVICAL

Prior Pap: ○Yes ○No

When (date, approximate if necessary): _____ Results: ○Normal ○Abnormal

Prior HPV: ○Yes ○No

When (date, approximate if necessary): _____ Results: ○Normal ○Abnormal

Have you had a hysterectomy: ○Yes, Date: _____ ○No

If Yes: ○Total Benign ○Partial, Intact Cervix ○ Total, Malignant ○Unknown ○Total, unspecified result

Have you been told you were high risk for cervical cancer? ○Yes ○No

BREAST

Prior Mammogram: ○Yes ○No

When (date, approximate if necessary): _____ Results: ○Normal ○Abnormal

Have you ever been diagnosed with breast cancer: ○Yes, age:_____ ○No

Have you been told you were high risk for breast cancer? ○Yes ○No

***Provider Note: if you have documentation of a high risk breast score, please upload.

Are you a smoker :

○No, not a smoker

○Yes, pick one: ○Referred to Quitline ○not interested in quitting

PROVIDER SECTION: What occurred today? (check all that apply)

Facility: _____ Date: _____

____ CBE – Results: Normal or Suspicious	____Pap
____ Screening Mammogram	____ HPV Co-Test
____Diagnostic: Bilateral or Unilateral (circle one)	____ Pelvic – Results: Normal or Suspicious
____ Ultrasound	____ Colposcopy
____Biopsy CPT Code: _____	____ Consult: breast or gyn (circle one)

Note: All diagnostics and rescreens outside the normal guidelines require a service request approval.

All radiology and lab/pathology reports should be uploaded into Med-IT.

Only CPT codes on the approved list of IDOH are eligible for reimbursement.

Indiana Programa de Cáncer de Mama Y Cuello Uterino

Date Completed / Fecha Completada (Validation Date): _____

DATOS PERSONALES – *Para ser completado por el paciente.*

Nombre *(apellido, primero, segundo)*: _____

Fecha de nacimiento: ____/____/____ *(mes, día, año)* Últimos 4 dígitos del Número Social: ____ ____ ____ ____ *(opcional)*

Dirección *(número y calle)*: _____ Departamento: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Condado: _____ Teléfono principal: (____)_____ Tipo de teléfono:_____

¿Cuál es su raza / etnicidad? *(Marque TODO lo que aplique.)*

- ☐ 1 Blanca
- ☐ 1 Blanca – Hispana
- ☐ 2 Negra o Afroamericana
- ☐ 2 Negra – Hispana
- ☐ 3 Asiática
- ☐ 3 Asiática – Hispana
- ☐ 4 Nativa de Hawaii o de otra Isla del Pacifico
- ☐ 4 Nativa de Hawaii o de otra Isla del Pacifico - Hispana
- ☐ 5 Indoamericana o Nativa de Alaska
- ☐ 5 Indoamericana o Nativa de Alaska- Hispana
- ☐ Multirracial
- ☐ No listada o desconocida

¿Cuál es el idioma principal que se habla en su hogar?

- ☐ 1 Ingles
- ☐ 2 Español
- ☐ 3 Arábico
- ☐ 5 Francés
- ☐ 13 Creole
- ☐ 6 Italiano
- ☐ 9 Polaco
- ☐ 14 Portugués
- ☐ 10 Ruso
- ☐ 4 Chino
- ☐ 7 Japonés
- ☐ 8 Coreano
- ☐ 12 Vietnamita
- ☐ 15 Hmong
- ☐ 11 Tagalo
- ☐ 16 Otro idioma: _____

¿Necesita traductor? ○ Si ○ No

REQUISITOS DE INGRESOS – *Para ser completado por el paciente.*
Las siguientes preguntas determinan su elegibilidad financiera.

1. Ingreso total antes de impuestos (ganado/recibido por usted o su cónyuge) en el último mes. Escriba $0 si no tiene ingresos. $ _____ mensual*

NOTA: Si usted es granjero o autónomo, use el ingreso neto (después de restar los gastos comerciales).

2. Numero de personas (usted incluida) que se mantienen de este ingreso: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 o más

3. ¿Tiene seguro médico? ☐ Sí ☐ No

4. Si es así, ¿Cuál es su cobertura médica?
   - ☐ Cobertura de Salud de Indiana – HIP
   - ☐ Cobertura de Salud de Indiana – Medicaid
   - ☐ Seguro del Mercado de Salud
   - ☐ Provisto por empleador (propio o del cónyuge)
   - ☐ Medicare Parte A solamente
   - ☐ Medicare Parte A y B
   - ☐ Medicaid de Emergencias solamente
   - ☐ Ninguno mencionado

Provider Notes:

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Data Entry Note: Last grade completed is for WISEWOMAN only.

Historia de salud: BCCP Indiana **Med-IT ID: _____**

Only do Health History if new to BCCP, had a new history of breast or cervical cancer, a hysterectomy, if you gave out smoking cessation information, or she is now high-risk.

CERVICAL

Papanicolaou previo: ○Si ○No

Cuando (fecha, aproximada si es necesario): _____ Resultados: ○ Normal ○Anormal

Detección previa del VPH: ○Si ○No

Cuando (fecha, aproximada si es necesario): _____ Resultados: ○ Normal ○Anormal

¿Has tenido una histerectomía? ○ Si, Fecha: _____ ○ No

Sí respondiste que si ○ Total, Benigno ○Parcial, Cuello uterino intacto ○Total, Maligno ○ Desconocido

○ Total, Resultado no especificado

¿Le han dicho que tiene alto riesgo de sufrir cáncer de cuello uterino? ○Si ○No

MAMA (SENO)

Mamografía previa: ○ Si ○ No

Cuando (fecha, aproximada si es necesario): _____ Resultados: ○ Normal ○ Anormal

¿Alguna vez le han diagnosticado cáncer de mama? ○Si, edad: _____ ○No

¿Le han dicho que tiene alto riesgo de sufrir cáncer de mama? ○ Si ○ No

***Provider Note: if you have documentation of a high-risk breast score, please upload

Eres fumadora (tabaco o vaporizador):

○ No, no fumadora

○ Si, elige uno: ○ Referida a Quitline (línea para dejar de fumar) ○No interesada en dejar de fumar

PROVIDER SECTION: What occurred today? (check all that apply)

Facility: _____ Date: _____

____ CBE – Results: Normal or Suspicious	____Pap
____ Screening Mammogram	____ HPV Co-Test
____Diagnostic: Bilateral or Unilateral (circle one)	____ Pelvic – Results: Normal or Suspicious
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