Florida Breast and Cervical Cancer Early Detection Program

PROGRAM APPLICATION PACKET

For questions regarding completion please call:

Manovna Narcisse, Regional Coordinator
Florida Breast and Cervical Cancer Early Detection Program
(FBCCEDP)
Phone: 407-858-1421

INSTRUCTIONS

Thank you for your interest in the Florida Breast and Cervical Cancer Early Detection Program (BCCEDP). We look forward to having you as a member.

Please fill out the enclosed application, read the privacy notice, and return the signed application. If you have questions, call (407) 858-1421; or, for deaf and hard of hearing individuals, please use Orange County 211 and give our number: (407) 858-1421.

Checklist to complete your BCCEDP application:

__ read and fill out the application (pages 1-2);
__ initial the yellow/gray boxes and sign the Authorization to Disclose Confidential Information Form (page 3);
__ sign the Annual Applicant Agreement form on page 4;
__ read the notice of Privacy Practices (pages 5 and 6);
__ sign the notice of Privacy Practices Acknowledgment Form (page 7);
__ attach a copy of your provider's referral or script to the application;
__ mail or fax us your signed application (pages 1-4 and 7);
__ keep the Notice of Privacy Practices (pages 5 and 6) for your records.

Mail your application to:

Florida Department of Health
In Orange County
6101 Lake Ellenor Dr.
Orlando, FL 32809

Confidential fax:

(407) 845-6116

Florida HEALTH Orange County

Appointment

Date/Time: _____/_____

Type of Appointment
(Circle only one): **Screening or Diagnostic**

Program Application

Effective: 07/01/2020

Section 2: Health History

Section 1: Applicants Information

SCREENING STATUS: __ INITIAL __ RESCREEN __ SHORT INTERVAL FOLLOW-UP (or REPEAT exam)

NAME (Legal or as it appears on Social Security Card):

_____

Last Name First Name M.I.

DATE OF BIRTH: (MM/DD/YYYY)

/ /

E-mail Address *(Optional)*:

STREET ADDRESS (REQUIRED):

_____

_____

PRIMARY PHONE NO. :(☐ HOME ☐ WORK ☐ CELL)

( )_____ - _____

ALTERNATIVE PHONE: (☐ HOME ☐ WORK ☐ CELL)

( )_____ - _____

IS IT OK TO LEAVE A MESSAGE? ☐Yes ☐ No

BEST TIME TO REACH YOU? ☐ Anytime ☐ 9:00 – 11:00

☐ 11:00 – 1:00 ☐ 1:00 – 3:00 ☐ 1:00 – 5:00

☐ After 5:00

RESIDENTIAL STATUS

☐ Florida Resident

☐ US Citizen or Resident or Alien Status

☐ Other (Tourist VISA)

WHAT IS YOUR?

Height ***in inches*:** _____

Weight ***in pounds*:** _____

ARE YOU OF LATINO OR HISPANIC ORIGIN?

1. ☐ Yes
2. ☐ No
3. ☐ Unknown

WHAT LANGUAGES DO YOU SPEAK?

Primary Language:

_____

Other Language:

_____

Do you have a history of Hypertension?

1.☐ Yes 2.☐ No

WHAT RACE OR RACES DO YOU CONSIDER YOURSELF?

(Choose all that Apply)

1. ☐ American Indian or Alaska Native
2. ☐ Asian
3. ☐ Black or African American
4. ☐ Native Hawaiian or Other Pacific Islander
5. ☐ Unknown
6. ☐ White

DO YOU USE TOBACCO PRODUCTS? 1.☐ Daily 2.☐ Some days 3.☐ Not at all 4. ☐ Declined to answer

If 1 or 2, was a smoking cessation program referral offered to you? 1.☐ Yes 2.☐ No

Referred to Quitline? 1.☐ Yes 2.☐ No

HOW DID YOU LEARN ABOUT THIS PROGRAM?

1.☐ Local ACS 2. ☐Direct Mail or Brochure 3.☐ CHD 4.☐ Community 5.☐ Family/Friend 6.☐ Internet

7.☐Medical Office 8. ☐ Clinic 9.☐ FQHC 10.☐ Postcard 11.☐ Reach & Connect 12.☐ Radio

FOR PROGRAM OFFICE USE ONLY:

THIS APPLICATION HAS BEEN: ☐ APPROVED ☐ DENIED Effective: _____(MM/DD/YYYY)

1. Breast Exam Background (Check Only One Box For Each Category) *Revised 9/4/2018*

Have you ever been diagnosed with BREAST CANCER? ☐ YES ☐ NO

When was your last MAMMOGRAM **before** enrolling in this program?

☐ Last MAMMOGRAM (month_____ /year_____) ☐ NONE ☐ Unsure (5+ years?)

	Average	High/Increased	Not Assessed	Unknown
Risk for Breast Cancer:	☐	☐	☐	☐

Do you have implants? ☐ YES ☐ NO

2. Cervical Exam Background (Check Only One Box For Each Category)

Have you ever been diagnosed with INVASIVE CERVICAL CANCER? ☐ YES ☐ NO

When was your last PAP SMEAR **before** enrolling in this program?

☐ Last PAP SMEAR exam (month_____ /year_____) ☐ NONE ☐ Unsure (5+ years?)

	Average	High/Increased	Not Assessed	Unknown
Risk for Cervical Cancer:	☐	☐	☐	☐

HYSTERECTOMY? ☐ **YES** ☐ **NO** **(** ☐ **Partial or** ☐ **Full) When?** _____

3. Has a medical provider ever told you that you were: (Check all that apply)?

☐	Pre-diabetic	☐	Diabetic
☐	High blood pressure	☐	High blood cholesterol

Referred to Services? ☐ YES ☐ NO

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	2020 DOH Scale Monthly Income	2020 DOH Scale Yearly Income
1	$2,126.58	$25,519.00
2	$2,873.25	$34,479.00
3	$3,619.92	$43,439.00
4	$4,366.58	$52,399.00
5	$5,113.25	$61,359.00
6	$5,859.92	$70,319.00
7	$6,606.58	$79,279.00
8	$7,353.25	$88,239.00
9	$8,099.92	$97,199.00
10	$8,846.58	$106,159.00

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_____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: FBCCEDP- Manovna Narcisse Phone #: 407-858-1421

Address: 6101 Lake Ellenor Dr Orlando, FL 32809 Fax #:407-845-6116

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____**Phone#:** _____

Address: _____ **Fax #:**_____

INFORMATION TO BE DISCLOSED: (Initial Highlighted Selection)

_____ General Medical Record(s)
_____ History and Physical Results
_____ Immunizations
_____ Prenatal Records
X____ Progress Notes
X_____ Consultations
X____ Diagnostic Test Reports (Specify Type of test(s)) _____

_____ Other: (specify) _____

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

_____STD ____HIV/AIDS _____TB ____Drug/Alcohol _____Mental Health _____WIC Eligibility _____Early Intervention

PURPOSE OF DISCLOSURE:

X____ Continuity of Care ____ Personal Use **X**____ Other (specify)__Provider Reimbursement & Care Coordination

EXPIRATION DATE: This authorization will expire (insert date or event) **one year from signature date**. 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.

X_____
Client/Representative Signature

X_____
Date

X_____
Printed Name

_____
Representative's Relationship to Client

X_____
Witness (optional)

_____
Date

Client Name: _____

ID#: _____

DOB: _____

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 co mpany, 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 ENrollmentinBCCEDP.
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 with in 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 determ ine 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: ORANGE Phone #: _____

_____ _____

Client Signature Date

_____ _____

Printed Name Date of Birth

Client Email Address: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the State's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction. However, in situations where you or someone on your behalf pays for an item or service in full, and you request information concerning said item or service not be disclosed to an insurer, the Department will agree to the requested restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

NOTICE OF PRIVACY PRACTICES (cont.)

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted. Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002). HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

DH150-741, 09/13

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I,_____WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

Original to file; Copy to client

DOB: _____

DH 3204-SSG-09-2019

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