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: PASCO _____ Phone #: (727) 619-0369

_____ _____

Client Signature Date

_____ _____

Printed Name Date of Birth

Client Email Address: _____

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

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 727-619-0369 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.