Florida Breast and Cervical Cancer
Early Detection Program

Patient Reporting Form (PRF)

☐ Enrollee into FBCCEDP

Lead Region: PASCO

Date Enrolled: _____

RC Initials: _____

RC Date Reviewed: _____

GENERAL INFORMATION

1. Basic Demographics

Full Name: _____
Last *First* *Middle Name* *Maiden Name*

Date of Birth: ___/___/____ **ID:** _____ **Telephone:** _____

Mailing Address: _____ **Email Address:** _____

_____
City *County* *Zip Code*

Hispanic? Yes ☐ No ☐

Race: (✓ all that apply)

☐ White	☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American	☐ American Indian or Alaska Native
☐ Asian	☐ Unknown

Primary Language: _____

2. Personal Health Information and Referrals

Height (inches): _____ **Weight (pounds):** _____

Has medical personnel ever told the client she was: (✓ all that apply)

☐ Pre-diabetic	☐ High blood pressure
☐ Diabetic	☐ High blood cholesterol
☐ Exercising 5x weekly	☐ Eating 5 servings of fruits/vegetables daily

Referred to WISEWOMAN Services: Yes ☐ No, not referred ☐ Declined referral ☐

Tobacco Use *(including vaping, e-cigarettes or similar products):* Daily ☐ Some Days ☐ Not at all ☐ Declined to answer ☐

Referred to Quitline: Yes ☐ No, not referred ☐ Declined referral ☐

3. Screening, Undocumented and How Learned of Program

Screening Status: Initial ☐ Rescreen ☐ Short-term Follow-up ☐

Undocumented: Yes ☐ No ☐

How did client learn about the program?

☐ ACS	☐ Billboards	☐ Brochures
☐ Bus wraps/bench/placards	☐ CHD	☐ Community
☐ Educational Session	☐ Family/Friend	☒ FQHC Name: Premier Community Healthcare
☐ In-reach	☐ Internet	☐ Medical Office
☐ Newspaper	☐ Outreach	☐ Postcard
☐ Radio	☐ Social Media	☐ Television

Other: _____

Name: _____ DOB: ___/___/____ Lead Region: PASCO

BREAST

4. Breast Risk Information and History *(Yes/No answers should be chosen if risk assessed and determined by provider)*

High Risk for Breast Cancer: Yes ☐ No ☐ Not Assessed/Unknown ☐

Symptoms: Yes ☐ No ☐

Has client ever had: breast cancer? Yes ☐ No ☐

a previous mammogram? Yes ☐ No ☐

Date of previous mammogram: ___/___/____

5. Clinical Breast Exam

CBE Result: Not performed ☐ Normal/ Benign ☐ Abnormality Suspicious for Cancer ☐ →

CBE Provider #: _____

CBE Screening Date: ___/___/___

CBE Paid by FBCCEDP: ☐ Yes ☐ No

Additional Breast Procedures for CBE

☐ Additional procedures needed or planned

☐ Additional procedures not needed or planned

6. Mammogram

Mam Provider #: _____

Mam Screening Date: ___/___/____

Mam Paid by FBCCEDP: ☐ Yes ☐ No

Indication for Mammogram

☐ Screening

☐ Diagnostic (Select one):

- ☐ Bloody or serous nipple discharge
- ☐ Cystic or solid mass
- ☐ First degree relative has/had breast cancer
- ☐ Nipple or areola scaliness
- ☐ Radiologist requested
- ☐ Skin dimpling or retraction
- ☐ Other suspicious findings (specify): _____

☐ Non-program mammogram.
Referred in for diagnostic evaluation
Breast Diagnostic Referral Date: ___/___/____

☐ No mammogram

☐ No breast service

☐ Unknown

Mammogram Result

☐ Negative (BI-RADS 1)
☐ Benign Finding (BI-RADS 2)
☐ Probably Benign/STFU suggested (BI-RADS 3)
☐ Unsatisfactory
☐ Result Pending
☐ Result unknown, presumed abnormal, mam from non-funded source

☐ Suspicious Abnormality (BI-RADS 4)
☐ Highly Suggestive of Malignancy (BI-RADS 5)
☐ Need evaluation or film comparison (BI-RADS 0)

Additional Procedures for Mammogram

☐ Additional procedures needed or planned
☐ Additional procedures not needed or planned
☐ Need or plan for additional procedures not yet determined.

7. Screening MRI (high-risk only)

MRI Pre-Authorization Date: _____

Central Office Nurse: _____

Screening MRI Provider#: _____

Screening MRI Date: ___/___/____

Screening MRI Paid by FBCCEDP: ☐ Yes ☐ No

Screening MRI Result

☐ Negative (BI-RADS 1)
☐ Benign Finding (BI-RADS 2)
☐ Probably Benign indicated (BI-RADS 3)
☐ Unsatisfactory
☐ Result Pending
☐ Not done

☐ Suspicious (BI-RADS 4)
☐ Highly Suggestive of Malignancy (BI-RADS 5)
☐ Known Malignancy (BI-RADS 6)
☐ Need Additional Imaging Evaluation (BI-RADS 0)

Additional Procedures for Screening MRI

☐ Additional procedures needed or planned
☐ Additional procedures not needed or planned
☐ Need or plan for additional procedures not yet determined.

Next mammogram date: ___/___/____

Name: _____ DOB: ___/___/_____ Lead Region: PASCO

CERVICAL

11. Cervical Cancer Risk Information and History (Yes/No answers should be chosen if risk assessed and determined by provider)

Risk for Cervical Cancer: Yes ☐ No ☐ Not Assessed/Unknown ☐

Previous Dx'd Cervical Cancer? Yes ☐ No ☐

Previous Pap Test? Yes ☐ No ☐ Unknown ☐

Date of Previous Pap? _____

12. Pap

Indication for Pap

- ☐ Screening
- ☐ Surveillance
- ☐ Non-program Pap. Referred in for diagnostic evaluation
  - **Cervical Diagnostic Referral Date:** ___/___/_____
- ☐ No Pap
- ☐ No cervical service
- ☐ Pap after primary HPV+
- ☐ Unknown

Pap Provider #: _____

Pap Screening Date: ___/___/_____

Pap Paid by FBCCEDP: ☐ Yes ☐ No

Specimen Type: ☐ Conventional Smear ☐ Liquid Based

Specimen Adequacy: ☐ Satisfactory ☐ Unsatisfactory

Pap Result

- ☐ Negative for intraepithelial lesion or malignancy
- ☐ Infection/Inflammation/Reactive Changes
- ☐ Atypical squamous cells of undetermined significance (ASC-US)
- ☐ Low Grade SIL (including HPV changes)
- ☐ Other _____
- ☐ Unsatisfactory
- ☐ Result Pending

- ☐ Atypical squamous cells cannot exclude HSIL (ASC-H)
- ☐ High Grade SIL
- ☐ Squamous Cell Carcinoma
- ☐ Atypical Glandular Cells
- ☐ Adenocarcinoma In Situ (AIS)
- ☐ Adenocarcinoma
- ☐ Result Unknown, presumed abnormal, Pap test from non-program funded source

Diagnostic Work-up Planned for Cervical Dysplasia or Cancer:

- ☐ Diagnostic work-up planned on basis of abnormal Pap test or pelvic exam
- ☐ Diagnostic work-up not planned
- ☐ Diagnostic work-up planned not yet determined

Next Pap date: ___/___/_____

13. HPV

Indication for HPV

- ☐ Co-Test/Screening
- ☐ Reflex (follow-up test after screening Pap)
- ☐ Test not done
- ☐ Unknown

HPV Provider #: _____

HPV Screening Date: ___/___/_____

HPV Paid by FBCCEDP: ☐ Yes ☐ No

HPV Result

- ☐ Positive with genotyping not done/Unknown
- ☐ Negative
- ☐ Positive with positive genotyping (types 16 or 18)
- ☐ Positive with negative genotyping (positive HPV, but not types 16 or 18)
- ☐ Unknown

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_____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.

Florida Breast and Cervical Cancer Early Detection Program

Florida HEALTH

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 HEALTH

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: FL. Dept. of Health-FL. Breast & Cervical Cancer Early Detection Program/WISEWOMAN & Premier

Agency Address: 11611 Denton Avenue Hudson, FL 34667-5420

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#: _____

DOB _____

Original to file; Copy to client

DH 3204-SSG-09-2019

Florida HEALTH

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: FL. Dept. of Health - FBCCEDP, WISEWOMAN & Premier **Phone #:** (727) 619-0369

Address: 11611 Denton Avenue Hudson, FL 34667-5420

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: State of Florida, and Centers for Disease Control & Prevention **Phone #:** (850) 245-4444

METHOD OF DISCLOSURE:

_____ **Pick up at Clinic/Facility**

_____ **Address:** _____

✓ **Fax #:** (850) 922-9321

✓ **Email Address: (please note that emailing may not be a secured method of communication)**

_____

INFORMATION TO BE DISCLOSED: (Initial Selection)

X General Medical Record(s) _____STD Records _____ TB Records X History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

X Progress Notes

X Diagnostic Test Reports (Specify Type of test(s) Mammogram, Ultrasound, Breast/Cervical biopsy reports, pathology reports

X Other: (specify) FBCCEDP imaging, visit notes and/or WISEWOMAN lab reports, visit notes etc.

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

_____HIV test results _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes X Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

X Continuity of Care ___Personal Use X Other (specify) Case management, Data Collection & Epidemiology.

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/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, appointment of a guardianship, order appointing personal representative, letters of administration)

Client Name: _____

ID#: _____

DOB: _____

DH3203-SSC 09/2017 Original: To File Copy: To Client Copy: To Accompany Disclosure

CLIENT CONSENT TO FAX CONFIDENTIAL INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. You must give specific written authorization to release certain types of sensitive medical information. The Florida Department of Health may fax confidential medical information to a provider or receive faxed information that was requested from a provider with your permission. Faxing such information is voluntary. You will not be denied services based on a refusal to allow your confidential information to be faxed.

Steps will be taken to make your information arrives safely, but faxes can be misdirected.

I _____ **do hereby authorize:** DOH - FBCCEDP / WISEWOMAN & Premier
(name of client/legal representative) (Agency or individual in possession of the record)

11611 Denton Avenue Hudson. FL 34667-5420
Address (street, city, state) of agency/individual with record

to fax the following information: (initial by any or all that apply)

_____ a. STD records _____ b. TB records _____ c. HIV/AIDS records
_____ d. Drug/alcohol treatment records _____ e. Psychiatric/psychological information/records
_____ f. Adult and child abuse information X g. Other (specify) FBCCEDP/WISEWOMAN reports & requested information

This information will be faxed to:

Provider Name (fax recipient)	FBCCEDP / WISEWOMAN
Contact Person	Lynda Gowing
Provider Phone Number	(727) 619-0369
Provider Fax Number	(727) 861-4805

Signature of Client or Legal Representative **Date** **Witness**

Legal Representative's Relationship to Client

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

Date Consent Revoked **Signature of Client or Legal Representative**

Witness **Legal Representative's Relationship to Client**

Client Name
ID Number
Date of Birth