BCCCNP
Breast and Cervical Cancer Control Navigation Program

BREAST AND CERVICAL CANCER CONTROL NAVIGATION PROGRAM

AGREEMENT FOR CLIENT PARTICIPATION AND PERMISSION TO OBTAIN RESULTS

SCREENOUTCANCER
National Breast & Cervical Cancer Early Detection Program

The Kalamazoo County Health & Community Services offers a Breast and Cervical Cancer Control Navigation Program (BCCCNP). This screening program, supported by the Federal Government and the Michigan Department of Health and Human Services, is part of a national plan to reduce the number of women without health insurance who die of breast or cervical cancer. Information here is also for Breast services in Wrap Around Program funded by Susan G. Komen Michigan.

PURPOSE OF THIS PROGRAM

The purpose of the BCCCNP is to find out if a woman has breast or cervical cancer and, if she has cancer, to assist her in obtaining cancer treatment. Regular screening tests can help find a cancer that may be present when it is still very small and easier to treat.

WHAT THE PROGRAM OFFERS TO YOU

Eligible women who meet the program income guidelines can receive the following services:

BREAST

- Women ages 40-64: breast **screening test (mammogram) and/or follow-up tests** (if needed) for an abnormal finding on a mammogram.
- Women ages 21-39: referred to BCCCNP with an **abnormal clinical breast exam (CBE) and requires breast diagnostic services**.

CERVICAL

- Cervical cancer screening includes a **Pap test and HPV test** (if indicated) according to the client's age.
    - Women ages 21-29: **Pap test ONLY** – HPV testing is unacceptable for this age group and not payable by the BCCCN program.
    - Women ages 30-65: **Pap test and HPV** testing as per BCCCNP medical protocol and cervical screening eligibility guidelines.
    - Women ages 21-64: referred to BCCCNP for cervical **follow-up tests** for an abnormal finding on a cervical screening test.

PROGRAM ELIGIBILITY: (**INITIAL**_____)

1. Upon enrollment I will be asked if I have health insurance. I will be eligible to receive program services If I meet the other criteria listed in this agreement **AND**:
    - I do not have health insurance **OR**
    - My health insurance DOES NOT cover breast/cervical cancer screening and/or follow-up services **OR**
    - My health insurance has a large deductible that must be paid prior to my receiving services and I am unable to pay the deductible.
2. If I gain insurance after I've enrolled, I must notify the BCCCNP and accurately report this information.
    - If I fail to do this, I understand that I will be responsible for the costs that result from any program services I receive.
3. The BCCCNP is available to women who live in Michigan or live near the border of a neighboring state (Indiana, Ohio, Wisconsin, Minnesota) who plan to receive screening and diagnostic services in Michigan.
    - I must notify the BCCCNP if my residency status changes.
    - If I provide incorrect information about being a Michigan resident or receiving services in Michigan, I will not be eligible for any further services and will be dis-enrolled from the BCCCNP.

NOTIFICATION OF TEST RESULTS AND FOLLOW-UP OF ABNORMAL RESULTS: (**INITIAL**_____)

1. I will be informed of the results of these screening tests and of any additional follow-up that may be needed.
2. Follow-up tests are offered following an abnormal breast and/or cervical cancer screening result.
3. It is my choice whether or not to follow the recommendations for follow-up of any tests that are abnormal.
4. If any screening test shows something that is abnormal, the BCCCNP agency will help me schedule follow-up exams through providers participating in the program.
5. If I have another provider, s/he will be informed of test results if I provide written approval to release this information.

CONTENTS OF THIS FORM REMAIN IN EFFECT ONE YEAR FROM DATE SIGNED OR UNTIL THE GRANT EXPIRES

BCCCNP
Breast and Cervical Cancer Control Navigation Program

BREAST AND CERVICAL CANCER CONTROL NAVIGATION PROGRAM

AGREEMENT FOR CLIENT PARTICIPATION AND PERMISSION TO OBTAIN RESULTS

SCREENOUTCANCER
National Breast & Cervical Cancer Early Detection Program

COST OF PROGRAM SERVICES: (**INITIAL**_____)

1. The costs of **program-approved** breast and/or cervical cancer screening and follow-up tests are covered by the program.
2. It is possible there may be other tests or procedures recommended to me by my provider.
    - If those recommended tests are not program-approved the BCCCNP cannot pay for those follow-up tests, exams, and/or additional charges.
    - If I am unable to pay, the BCCCNP agency will work with me to help me receive needed services. (i.e. financial assistance and setting up a payment plan if needed)
3. I understand that I should ask the BCCCNP agency what follow-up tests are **program-approved** before completing follow-up tests. I understand that if I have follow-up tests that are not program-approved that I may be responsible for the charges.

IF BREAST OR CERVICAL CANCER IS DIAGNOSED: (**INITIAL**_____)

1. The BCCCNP does not pay for any treatment services for breast or cervical cancer.
2. If breast or cervical cancer is diagnosed, the BCCCNP agency will determine if I am eligible to participate in a BCCCNP-specific Medicaid program that will provide insurance coverage for my cancer treatment.
    - By initialing above, I understand that once I have completed cancer treatment and/or am no longer eligible for the BCCCNP, this insurance coverage will end.
3. If I am not eligible for treatment coverage through this Medicaid program, the BCCCNP agency will work with me to help me receive treatment. (i.e. financial assistance and setting up a payment plan if needed)

I UNDERSTAND THAT:

- Any personal information obtained about me will be treated as confidential.
- Signing this form grants permission for my providers to share my information and test results with BCCCNP staff.
- Information about my tests results will be used by BCCCNP staff to assist me with obtaining care.
- Information about me that does not identify me will be used in grouped reports or for other reporting purposes concerned with controlling breast and cervical cancer.

I GIVE PERMISSION AND AGREE TO:

- Provide the BCCCNP Local Agency and staff administering the program with information about me, including my health history and reports of screening and follow-up tests and procedures relating to breast or cervical cancer.
- Allow the BCCCNP staff to assist me as needed in obtaining breast and cervical cancer screening services.
- Allow the clinics, physicians, hospitals and other health care facilities, to which I am referred, give information concerning breast or cervical screening, diagnosis and treatment services I receive to the BCCCNP and Michigan Department of Health and Human Services.
- Have the BCCCNP Local Agency staff contact me in the method I prefer (phone, email) and leave a message for me about my care. (**INITIAL**_____)

This program has been explained to me and my questions have been answered. Based on my understanding, I have decided to participate in the BCCCNP. I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll.

The BCCCNP agency phone number is 888-243-4087.

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

Fax this completed form to LCA @ 269-373-5362

CONTENTS OF THIS FORM REMAIN IN EFFECT ONE YEAR FROM DATE SIGNED OR UNTIL THE GRANT EXPIRES