

Be Active ~ Be Healthy

Office of Women's and Men's Health Enrollment for

Every Woman Matters Program & Nebraska Colon Cancer Screening Program

Breast & Cervical Cancer Screening

Services covered for **Women ages 40-74**

- Clinical Breast Exam (CBE)
- Mammograms
- Pelvic exam and Pap test

Cardiovascular & Diabetes Screening

Services covered for **Women ages 40-74**

- Blood Pressure check
- Cholesterol check
- Blood Sugar (glucose) check

Colon Cancer Screening

Services covered for **Nebraska Men and Women 50-74**

- Fecal Occult Blood Test (FOBT) for home testing; or
- Colonoscopy - if eligible

Preventive Health Services

Services covered for **All clients**

- Health and Wellness information
- Referral to quit tobacco use - Nebraska Tobacco Quitline - 1.800.784.8669 or QuitNow.ne.gov

Office of Women's and Men's Health
Every Woman Matters Program
Nebraska Colon Cancer Program
301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817
Toll-Free: 800.532.2227
In Lincoln: 402.471.0929
Fax: 402.471.0913
Websites: www.dhhs.ne.gov/womenshealth
www.dhhs.ne.gov/menshealth
www.dhhs.ne.gov/crc

2011 - #5U58/DP000811-04; 5U58/DP001421-03; 5U58/DP002043-02



Every Woman Matters/NE Colon Program Enrollment *To use this form you must be 40-74

Reasonable accommodations made for persons with disabilities. TDD (800)833-7352. Nebraska DHHS provides language assistance at no cost to limited English proficient persons who seek our services.

July 2011



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CLIENTS:

- Read, fill out, sign and date Pages 2-4.
- All gray shaded areas must be filled out.
- You will not be enrolled unless these pages are completed.



You are **NOT** eligible for the Every Woman Matters Program (EWM) or Nebraska Colon Cancer Screening Program (NCP) services if you are:

- Under the age of 40 (EWM)
- Under the age of 50 (NCP)
- Over the age of 74
- Have Medicaid, Medicare Part B or HMO (Health Maintenance Organization) insurance
- Over income guidelines (*income guidelines found at www.dhhs.ne.gov/womenshealth/ewm*)

If you are under age 40 or over age 74, talk to your health care provider about what preventive services are right for you.

FOR COLON CANCER SCREENING PROGRAM (Nebraska women and men 50-74 ONLY):

- Client is not eligible for colon cancer screening services until the forms are returned to the central office and reviewed by clinical staff. Once information is reviewed, the client will be notified as to eligibility for the Nebraska Colon Cancer Screening Program and which colon test the client is eligible for. Clients must have a primary care doctor. Results of the testing will be sent to both the client and provider.

First Name		Middle Initial	Last Name		Maiden Name	Birthdate / /
Gender M / F	Social Security #		Address			
City			County	State	Zip	
Home Phone () ()		Work Phone () ()			Cell Phone () ()	
<i>In case we can't reach you:</i> Contact person: _____ Relationship: _____ Phone: () _____ Address: _____ City: _____ State: _____ Zip: _____				How did you hear about the program? <input type="checkbox"/> doctor/clinic <input type="checkbox"/> family/friend <input type="checkbox"/> agency <input type="checkbox"/> newspaper/radio/TV <input type="checkbox"/> self-referral <input type="checkbox"/> outreach worker <input type="checkbox"/> other _____		
What race or ethnicity are you? <input type="checkbox"/> American Indian/Alaska Native Tribe _____ <input type="checkbox"/> Black/African American <input type="checkbox"/> Mexican American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown				Highest grade in school you completed: <i>circle one</i> 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+		
Are you of Hispanic/Latina origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Country of origin _____				What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		
I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills.						
What is your household income before taxes? <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Income: \$ _____ <input type="checkbox"/> Yearly <i>Please Note: Self employed are to use net income after taxes.</i>				Do you have: <input type="checkbox"/> Medicare Part A and B <input type="checkbox"/> Medicare Part A only <input type="checkbox"/> Medicaid (full coverage for self) <input type="checkbox"/> None/No Coverage <input type="checkbox"/> Private Insurance with or without Medicaid Supplement (please list) _____		
How many people live on this income?				Is your insurance an HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No (An HMO is a health maintenance organization)		

- You must **read pages 3-4** to be a part of the Every Woman Matters Program and Nebraska Colon Cancer Screening Program. **You are NOT enrolled until page 4 is signed and dated.**

EVERYWOMANMATTERS (WOMEN)

- ❖ I want to be a part of the **Every Woman Matters (EWM) Program**. I know:
 - ❖ I must be between 40 and 74 years of age to receive services
 - ❖ I cannot be over income guidelines
 - ❖ I cannot have Medicaid, Medicare Part B, or an HMO
 - ❖ I must be a female (per Federal Guidelines)
 - ❖ I can notify EWM if I do not wish to be a part of this program anymore
- ❖ I know that if I am 40-74 years of age I am eligible for full screening services under the EWM Program.
- ❖ I know that if I am 40-74 years of age, I may receive breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon program guidelines. I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.
- ❖ I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.
- ❖ I have talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM.

NEBRASKA COLON CANCER SCREENING PROGRAM (MEN and WOMEN)

- I want to be a part of the **Nebraska Colon Cancer Screening Program (NCP)**. I know:
 - I must be between 50 and 74 years of age to receive services (*there are no exceptions*)
 - I cannot be over income guidelines
 - I cannot have Medicaid, Medicare Part B, or an HMO
 - I must re-enroll in NCP every year
 - I must have a primary care doctor listed
 - I can notify NCP if I do not wish to be a part of this program anymore
 - I must be a Nebraska resident
- If I am eligible to participate, I understand that NCP will look at my health history and tell me what colon cancer screening test I am eligible for.
- Based upon my health history and what type of test I am eligible for, I know that NCP may provide me with a Fecal Occult Blood Test (FOBT) kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive an FOBT **from the program** and have a positive test, it may be followed up with a colonoscopy.
 - If I receive a colonoscopy through NCP I understand that I will be asked to pay 10% of the cost.
 - I understand that my payments will help others with colonoscopy costs through NCP.
- I will talk with my health care provider about the screening test(s) for colon cancer and understand possible side effects or discomforts.
- I will talk with the clinic about how I am going to pay for any tests or services that are not paid by NCP.
- I understand that NCP does not pay for treatment if I am diagnosed with colon cancer. NCP staff will assist me in finding treatment resources.

Informed Consent and Release of Medical Information

(Continued)

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- ◆ I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM/NCP may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- ◆ Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM/NCP, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
- ◆ My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and cervical cancer screening, heart disease and diabetes screening, follow up exams, colorectal screening, diagnostic tests and/or treatment to EWM/NCP.
- ◆ To assist me in making the best health care decisions, EWM/NCP may share clinical and other health care information including lab results and health history with my health care providers.
- ◆ My name, address, social security number and/or other personal information will be used only by EWM/NCP. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- ◆ Other information may be used for studies approved by EWM/NCP and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

In order to be eligible for EWM/NCP you must be a U.S. Citizen or a qualified alien under the federal Immigration and Nationality Act. Please check which box applies to you.

- ◆ For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

OR

I am a qualified alien under the federal Immigration and Nationality Act. **I am attaching a front and back copy of my USCIS documentation.**

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Please Print Name (first, middle, last)

Client Signature

Date of Signature/Enrollment

Client Date of Birth