Maine Breast and Cervical Health Program
Initial Enrollment Form

Office Use Only: Screening Day _____________
Enrollment Backdated: ___ ___ /___ ___ / ___ ___

Note: Please put an answer on each line or this form may be returned to you.

Please Print:

Name (First, MI, Last): ________________________________ Home Phone: (_ _ _) __ __ __ - __ __ __ __

Home Mailing Address: ________________________________ Work Phone: (_ _ _) __ __ __ - __ __ __ __

City: ________________________________ State: ________ Zip: ___ ___ ___ ___ ___

Date of Birth: __ __ / __ __ /__ __ __ __ (Month Day Year) Social Security: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Contact Person (in case we can not reach you): ______________________Phone: (_ _ _) ___ ___ ___ - ___ ___ ___ ___

Please check a box for each question below:

Are you Spanish, Hispanic or Latina? ❑ Yes ❑ No

Are you: ❑ White ❑ African American ❑ Asian ❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native ❑ Other: Specify ______________________________

INCOME:

$_____________ / Year *****Line 22 on Tax Form 1040*****
(Plus any additional wages, alimony, unemployment, worker's compensation, social security, etc.)

_____________ **Number of people (including yourself) who are supported by this income**
(Include ALL individuals in the household that are claimed on income taxes)

HEALTH CARE COVERAGE:

Do you have Medicare Part A? ❑ Yes ❑ No

Do you have Medicare Part B? ❑ Yes ❑ No

Do you have MaineCare (Medicaid)? ❑ Yes ❑ No

Do you have any health insurance? ❑ Yes** ❑ No

****IF YES, ANSWER ALL BELOW****

** If yes, does your health insurance have a small co-payment and NO deductible? ❑ Yes ❑ No

** $______________ Insurance Deductible

** Name of Insurance Company: ____

** Insurance Company Phone Number: (___ ___ ___) ___ ___ ___ -___ ___ ___ ___

** Name of policy holder: _____________________ **Date of Birth policy holder: __ __/__ __/__ __ __ __

** Policy Holder's Social Security #: __ __ __ - __ __ - __ __ __ __

** Policy #: _______________________________ **Group #:___________________________________

** Is Insurance through your (or your spouse's/partner's) employer? ❑ Yes ❑ No

** If yes, Name of employer: ____

Signature: ____ **Today's Date:** ___ ___ / ___ ___ /___ ___ ___ ___

(Go To Next Page and Complete)

OFFICE USE ONLY: *PCP Site Name:* _______________________________________ *Site Number:*________________

Maine Breast and Cervical Health Program Consent
Initial Enrollment Form

Health Information Questions:

Before joining this program, had you ever had a **Mammogram**? ❑ Yes ❑ No
If YES, date last done: ___ ___ / ___ ___/ ___ ___ ___ ___

Before joining this program, had you ever had a **Pap test**? ❑ Yes ❑ No
If YES, date last done: ___ ___ / ___ ___/ ___ ___ ___ ___

Have you had a **hysterectomy**? ❑ Yes ❑ No
If YES, date done: ___ ___ / ___ ___/ ___ ___ ___ ___
If YES, was it for cervical cancer? ❑ Yes ❑ No
Do you still have any part of your cervix remaining? ❑ Yes ❑ No ❑ Don't know

How did you hear about the Maine Breast and Cervical Health Program (only check one)?

❑ ACES ❑ Brochure ❑ CAP ❑ Coalition ❑ Doctor/Nurse ❑ Family/Friend ❑ Hospital

❑ Mammography site ❑ Newspaper ❑ Radio ❑ Television ❑ Tribe

❑ Other (list ____________________________)

Consent Statement:

By signing the Consent Statement below I agree to let the Maine Breast and Cervical Health Program:

- Collect information about me and my breast and cervical cancer screenings, diagnosis and treatment, if necessary;
- Contact me to ask questions to help improve the Program and contact me to offer assistance in obtaining services;
- Contact my doctors for my screening and test results and contact me with my screening and test results.

All information about me and my screenings and tests is kept private and completely confidential. Please read the Consent Statement below and sign your name with today's date. If you have any questions about the consent please call 1-800-350-5180, TTY (Deaf or Hard of Hearing) 207-287-8015.

The Maine Breast and Cervical Health Program (the Program) collects information from all participants in order to receive funding from the federal government. Any information turned over to the Program will be treated confidentially in accordance with the provisions of 22 M.R.S.A. §1711-C, which means the information will be used to meet the purposes of the Program and any published reports which result from this Program will not identify me by name. By agreeing to take part in the Maine Breast and Cervical Health Program, I understand that I may be contacted to provide information to evaluate the Program and may be offered case management services. In addition, I give my permission for all of my health care providers, clinics, hospitals, mammography facilities, labs, and/or health insurance providers to provide all information concerning my Pap smears, breast exams, mammograms, radiological or laboratory results and/or care and treatment related to the Program. Such information may include services covered by the Program and delivered up to three months prior to the date of my signature on this form. I understand that once I have had a Maine Breast and Cervical Health visit, the Program will be allowed to obtain medical information for all breast and/or cervical procedures, cancer screenings, diagnosis and treatment. I understand that I have a right to request a copy of my Program records pursuant to 22 M.R.S.A. §1711-B and may request that amendments be made to any incorrect or incomplete information contained in my records if my request is submitted in writing. I understand that notifying me of test results is a very important purpose of this Program, and that all available resources may be used to notify me if I have an abnormal test result.

I understand that my participation in this Program is voluntary and that I may drop out of the Program and withdraw my consent at any time.

Signature: ____________________________________ **Today's Date**: ___ ___ / ___ ___ /___ ___ ___ ___

Return Form to: MBCHP, 11 State House Station, Augusta, ME 04333
or Fax to: (1-800) 325 - 5760