



SCREENING

Client Enrollment

EVERY WOMAN MATTERS

Where to Begin

- A Healthy Lifestyle Questionnaire (HLQ) is required to be filled out yearly for each client.
- The HLQ should be returned to the Every Woman Matters office for approval **PRIOR** to service.
- Incomplete forms will be returned and possibly delay screening.



Healthy Lifestyle Questionnaire



Please fill out this form. Filling out this form will help Every Woman Matters (EWM) and the Nebraska Colon Cancer Screening Program (NCP) determine what services are best for you.

Even if you are not able to get services, you can still get health education.

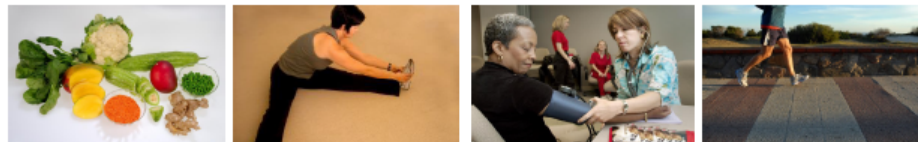
WHAT YOU NEED TO KNOW:

- You must **NOT** have health insurance that would pay for preventive services.
- Please answer **ALL** questions. If you don't we will call you or send the form back to you and this could delay important health screenings.
- Please **PRINT** clearly. Use a **black or blue** ink pen. Do **not** use pencil.
- This is **NOT** your screening card. Please do **not** make an appointment with your health care provider until you get a Screening Card.
- After you send this to EWM/NCP, it will be reviewed to see what screenings you are eligible for. This usually takes up to 2 weeks.
- Once the program determines what screenings you are eligible for, a Screening Card and this HLQ, will be returned in the mail so that you can take them to your appointment to give to your healthcare provider.

WHAT YOUR PROVIDER NEEDS TO KNOW:

- Screenings were determined based upon the HLQ submitted to EWM/NCP.
- This HLQ was mailed back to the client with a Screening Card. Client was instructed to bring the form so you can discuss benefits of healthy lifestyle behaviors.
- Clinics may keep the HLQ as a part of the client chart, if so desired.

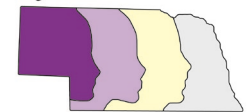
Thank you for taking time for your health!



How can I help my patients access Every Woman Matters?

- ▶ Know what services are covered by the program
- ▶ Keep HLQ's on hand in your office for patients to fill out and send in or direct them to the EWM website to complete the questionnaire online
- ▶ Assist patients in completing the forms if needed
- ▶ Fax: 402-471-0913 or e-mail: dhhs.everywomanmatters@Nebraska.gov
completed HLQ's to Every Woman Matters for patients
- ▶ If the patient is experiencing an issue such as a breast lump or has had an abnormal pap she could be eligible for immediate services through our diagnostic enrollment. Instructions and forms can be found here: dhhs.ne.gov/ewmforms

Every Woman Matters



Obtaining Healthy Lifestyle Questionnaires

- ▶ Online enrollment is available at dhhs.ne.gov/ewm. Click the “Enroll Now” button under page navigation panel on the top left.
- ▶ Clients may request a HLQ via mail by calling 1-800-532-2227 and leaving a message on the enrollment line. Enrollments are mailed daily.
- ▶ Keep HLQ’s on hand in your office* by downloading copies from our website. Materials can be downloaded at dhhs.ne.gov/ewmforms


* clients are not eligible for screening until they receive a screening card

General Forms


[Provider Materials Re-Order Form](#) 

[Inflatable Colon Rental Information](#) 

[Healthy Lifestyle Questionnaire](#) 


[Healthy Lifestyle Questionnaire \(Spanish\)](#) 

[Women Deemed Lost to Follow Up Form](#) 

[Treatment Funds Request Form](#) 

[Claim Status Form](#) 

[Payment Status Form](#) 

[Mammography Order Form](#) 

[Tobacco Free Nebraska Quitline Fax Referral](#) 

Program Eligibility

Every Woman Matters



Informed Consent and Release of Medical Information

Version: August 2017

- I know that:
 - 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, email, 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 Prevention and Control (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.

- I am a citizen of the United States.
- I am a qualified alien under the federal Immigration and Nationality Act. I am attaching a front copy of my USCIS documentation. (example: permanent resident card)

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

Your Signature _____
Please Print Your Name (first, middle, last) _____
Date of Your Signature _____
month / day / year
Your Date of Birth _____
month / day / year
Be Sure to Print Your Name, Sign and Date

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: Please answer each question and PRINT clearly!

Version: August 2017

First Name: _____ Middle Initial: _____ Last Name: _____
Maiden Name: _____ Marital Status: Single Divorced Married Widowed Gender: Female Male
Birthdate: month / day / year Social Security #: _____ Birth Place: _____
Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Preferred way of contact: Home Work Cell
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Yes I want to receive program information by email. Email: _____
In case we can't reach you:
Contact person: _____ Relationship: Spouse Family/Friend Other
Phone: (____) _____ Home Work Cell

Address: _____ City: _____ State: _____ Zip: _____

Are you of Hispanic/Latina(o) origin? Yes No Unknown

What is your primary language spoken in your home? English Spanish Vietnamese Other _____

What race or ethnicity are you? (check all boxes that apply)
 American Indian/Alaska Native Tribe
 Black/African American
 Mexican American
 White
 Asian
 Pacific Islander/Native Hawaiian
 Other _____
 Unknown

Are you a Refugee? Yes No DK* If yes, where from: _____

Highest level of education completed: 9th grade Some high school High school graduate or equivalent
 Some college or higher Don't know Don't want to answer

How did you hear about the program: Doctor/Clinic Family/Friend
 Newspaper/Radio/TV I am a Current/Previous Client
 Other _____

I will be required to show proof that my income is within the program income guidelines when I am called. If I am found to be over income guidelines, I will be responsible for my bills for services received.

What is your household income before taxes? Weekly Monthly Yearly Income: \$ _____
Please Note: Self employed are to use net income after taxes.

How many people live on this income? 1 2 3 4 5 6 7 8 9 10 11 12

Do you have insurance? Yes None/No Coverage If yes, is it: Medicare (for people 65 and over)
 Part A Part B Part C
 Medicaid (full or partial)
 Private Insurance (please list) _____

4 You're On a Roll...Continue to Page 5

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: Please answer each question and PRINT clearly!

Version: August 2017

***ONLY women need to answer the questions in this box**
Have you ever had any of the following tests?
PAP test
Most Recent Date: _____
The result: Normal Abnormal DK*
Have you ever had a hysterectomy (removal of the uterus)? Yes No DK*
2a. Was your cervix removed? Yes No DK*
2b. Was your hysterectomy to treat cervical cancer? Yes No DK*
Have you ever had cervical cancer? Yes No DK*
When: _____

Mammogram
Most Recent Date: _____
The result: Normal Abnormal DK*
Have your mother, sister or daughter ever had breast cancer? Yes No DK*
When: _____
Have you ever had breast cancer? Yes No DK*
When: _____

1. How many 1st degree relatives, excluding yourself, (parents, brothers, sisters, children) told they have colon cancer or rectal cancer? _____
2. How many of those family members with colon cancer were under the age of 60? _____
3. How many of those family members with polyps in the colon were under the age of 60? _____
4. How many of those family members with polyps were under the age of 50? _____
5a. What type of polyps did they have? _____
5b. Have you ever been told that you have had polyps in the colon? Yes No DK*
6. How many polyps did you have? _____
7. Have you ever had any of the following tests? (Dates and results need to be marked):
Sigmoidoscopy Were polyps removed? Yes No DK* Most Recent Date: _____ The result: Normal Abnormal
Colonoscopy Were polyps removed? Yes No DK* Most Recent Date: _____ The result: Normal Abnormal
Double Contrast Barium Enema (DCBE) Were polyps removed? Yes No DK* Most Recent Date: _____ The result: Normal Abnormal

8. Have you ever been told by a doctor, nurse, or other health professional that you have had:
Familial Adenomatous Polyposis (FAP) Yes No DK*
Hereditary Non-Polyposis Colorectal Cancer (HNPCC) Yes No DK*
Inflammatory Bowel Disease (IBD) Yes No DK*
Ulcerative Colitis Yes No DK*
9. Are you currently under a doctor's care for any of the above conditions? Yes No DK*
10. Within the last 30 days have you had bleeding from the rectum?
10a. What did your doctor say about your rectal bleeding?
 Yes No DK*
 Yes No DK*
 Yes No DK*
11. Have you ever been told that you have had colon or rectal bleeding?
 Yes No DK*
 Yes No DK*
12. My Every Woman Matters or Primary doctor is: (please print)
Name of Clinic: _____
First Name: _____ Last Name: _____
Date of Birth: _____ City: _____ Phone: _____

Keep Moving for Your Health! 5

Determining Eligibility

Information gathered from the client's HLQ will be used to determine whether or not they will be eligible for services and when it is appropriate for them to be screened.

Who is Eligible



Uninsured Clients
ages 35-74



United States
Residents



Income Eligible

Who is Eligible – Uninsured Clients



Uninsured Clients ages 35-74

In order to be eligible, screening clients must not have other health coverage that will pay for preventive services.

- Clients with Private Health Insurance, Medicare Part B or Medicaid are **not eligible** for screening services if their coverage includes preventive services.
- If their plan does not cover preventive services, they will need to send a copy of their insurance policy with their HLQ for consideration.
- Diagnostic clients with private insurance may still be eligible for EWM! Call to speak with a staff nurse about enrollment.

Who is Eligible – United States Residents



United States Residents

Must be a citizen or permanent resident of the United States.

Clients must comply with Neb. Rev. Stat. §§4-108 through §§4-114, being either a US citizen or Qualified Alien under the Federal Immigration and Nationality Act.

- Qualified Aliens **must** submit a front **and** back copy of their Permanent Resident Card with their application.
 - Their status will be checked in the Federal SAVE System before program approval.
 - Passports, Work VISA's, etc. **are not** sufficient proof of residency for this program.

Who is Eligible – Income Guidelines



Income Guidelines

Eligible clients must be within 250% of the Federal Poverty Guidelines.

Current income guidelines can be found at <http://dhhs.ne.gov/ewmforms>

Household income is self-reported. No verification or documentation of income is required. Enrolling clients report their gross annual income before deductions. All persons living in the same house and being supported by the income are to be included in the number of people in the household. All income coming into the home that supports the household is to be counted.

- Those with farm incomes or non-farm self-employment are asked to record the amount of net income after business deductions.
- If the client has no income, it is still required to report as “0” to avoid a delay in processing.

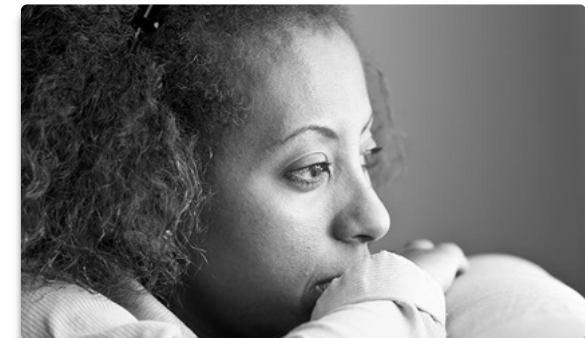
Other Factors that Determine Eligibility



USPSTF Guidelines



Screening History



Personal History

Determining Eligibility– USPSTF Guidelines



USPSTF Guidelines

Is it appropriate for the client to be screened?

USPSTF Screening Guidelines	
Cervical Cancer	Breast Cancer
Women 21-29 Grade: A Screen with cytology (Pap smear) every 3 years.	Women aged 50 to 74 years Grade: B Biennial screening mammography for women aged 50 to 74 years.
Women 30-65 Grade: A Screen with cytology every 3 years or co-testing (cytology/HR-HPV testing) every 5 years or screen every 5 years with HR-HPV alone.	Women aged 40 to 49 years Grade: C The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.
Colon Cancer	
Men and Women 45-74 Grade: B Screening for Colon Cancer with any of the following tests:	
<ul style="list-style-type: none"> • FOBT/FIT Annually* • Colonoscopy every 10 years * 	
<i>Other approved tests by USPSTF: https://www.uspreventiveservicestaskforce.org/Page/Document/Recommendation-StatementFinal/colorectal-cancer-screening2</i>	
<i>*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.</i>	

Screening services covered for reimbursement must adhere to the U.S. Preventive Services Screening Task Force (USPSTF) Guidelines

www.uspreventiveservicestaskforce.org/

Determining Eligibility – Screening History



Screening History

Services are determined by screening dates that the clients have self reported in their HLQ and past Every Woman Matters records.

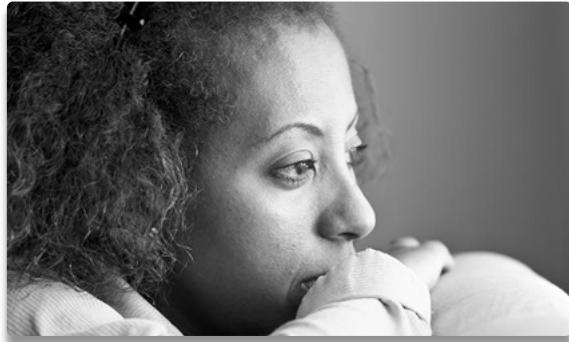
An Every Woman Matters Screening Covers:

- Clinical Breast Exams
- Screening mammograms for women 40-74 every 2 years
- Screening Pap Tests for women 40-64 every 3 years with cytology or every 5 years with cytology/HPV
- Cardiovascular screening for women 35-64 in conjunction with an eligible breast or cervical screening
 - Cholesterol, Triglycerides, A1c/Blood Glucose

Existing clients are automatically sent HLQ's a month prior to their due dates as determined by previous program records.

Clients who are deemed not due for services will be sent notice via mail.

Determining Eligibility – Personal History



Personal History

Does the client have a personal history of cancer?

Screening mammograms/Pap tests may be performed yearly if the client has had a personal history of breast/cervical cancer.

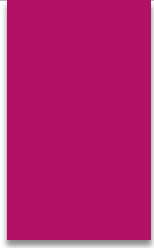
Clients with a documented personal history of BRCA1 or BRCA2 gene mutations only:

Clients age 25-39: Eligible for annual breast MRI screening (A screening mammogram is not reimbursed by EWM)

- Initiation of screening would be individualized based on earliest age of onset in family
- MRI must be preapproved by EWM

Clients age 40-74: Annual screening mammogram at the time of her EWM screening visit or immediately afterward,

- Breast MRI Screening alternating 6 months after the screening mammogram



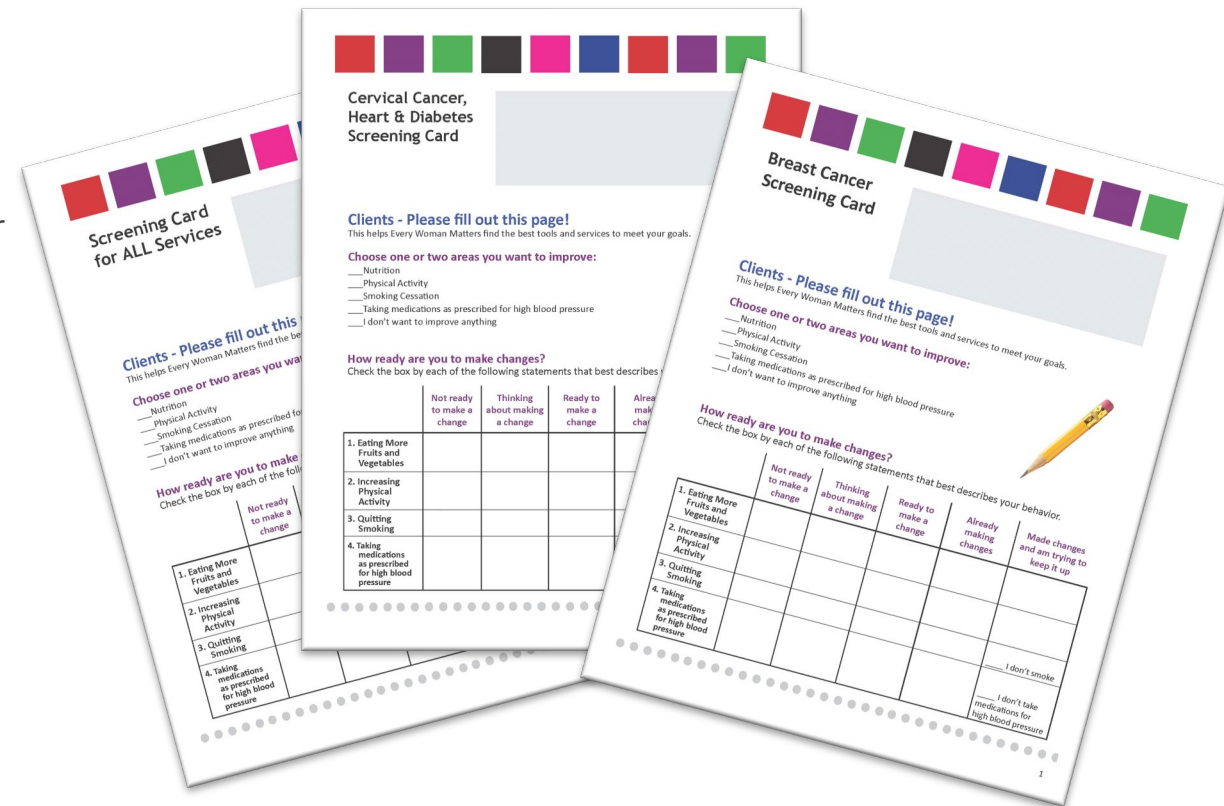
Screening Cards

Every Woman Matters



Screening Cards - Client Responsibility

- ▶ Once approved, the client will receive:
 - Their completed HLQ to bring to their appointment to discuss the answers with their provider
 - Fax referral for the Tobacco QuitLine *if applicable
 - Home based colon cancer screening test kit (FIT Test) *if applicable
 - Instructions for their next steps
 - Screening card
- ▶ The screening card lets the client as well as the provider know the services covered by the program



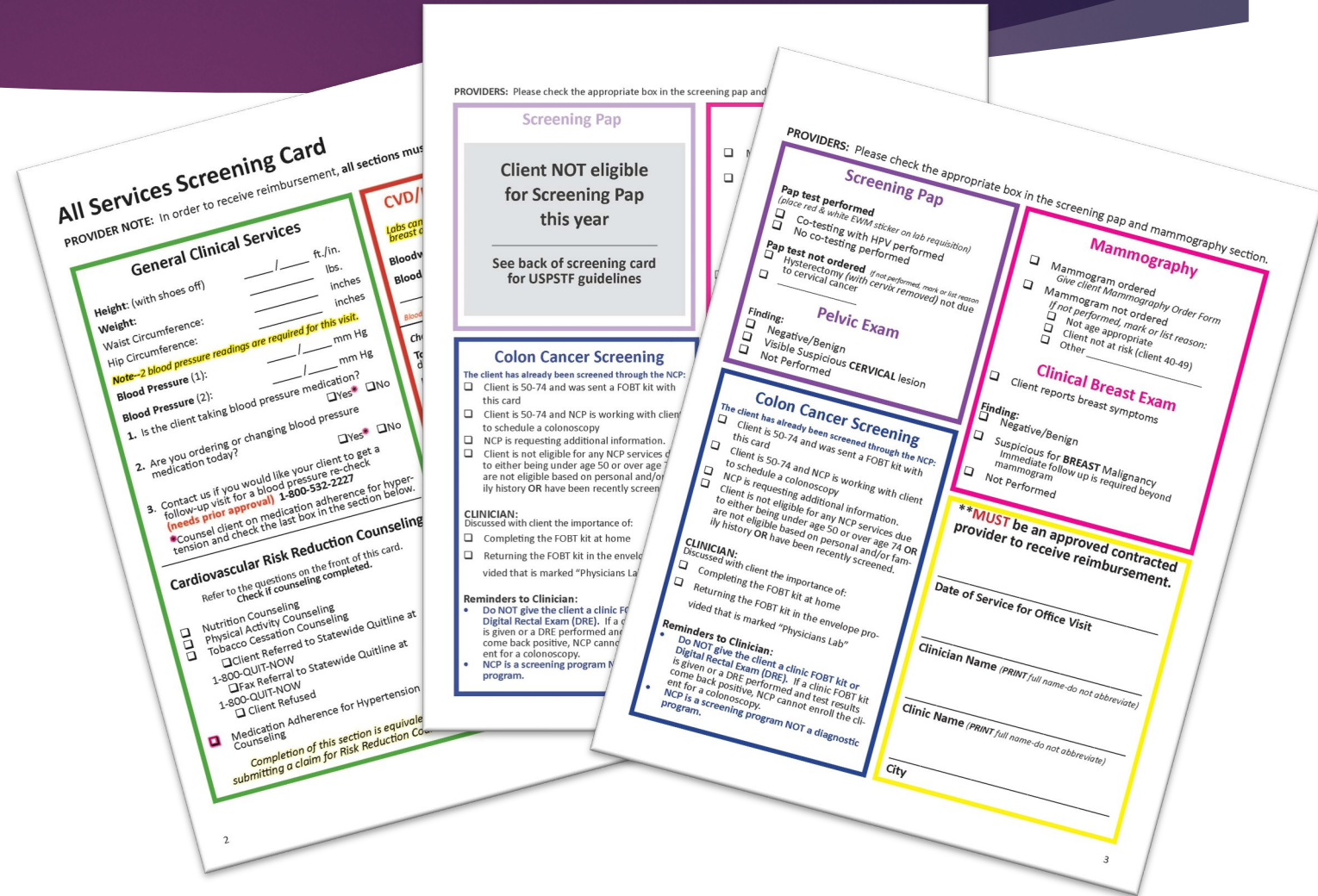
Screening Cards – Provider Responsibility

In order to be reimbursed for services:

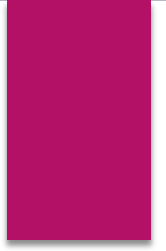
- ▶ The client must be seen at a clinic/provider that has been approved by EWM
- ▶ Screening cards must be filled out completely and returned to EWM within 2 weeks

Other items to remember:

- ▶ If eligible, give the client a mammography order form to bring to their radiology appointment



Frequently Asked Questions



EWM FAQ

- ▶ **Will the client be notified if they are not eligible?**
We will notify the client within 10 business days via mail whether or not they are eligible.
- ▶ **Are there services for women who are under 35?**
Diagnostic services are available and Pap/HPV/STD testing may be provided under the State Pap Plus Program. See [provider manual](#) for details.
- ▶ **If a client comes to the clinic without their screening card can we call you to fax us one?**
If the client has completed an HLQ and is eligible for services, a screening card may be faxed to the clinic.
- ▶ **Does the lab draw have to be done the same day as their office visit?**
Labs must be done within 30 days of the office visit.
- ▶ **What if the clients screening has an abnormal result?**
Diagnostic testing may be covered per ASCCP Consensus Guidelines and NCCN Clinical Practice Guidelines. See [provider manual](#) for details.

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Additional Questions Regarding Screening Enrollment?

Contact an Every Woman Matters representative:

Women's & Men's Health Programs

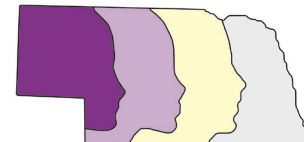
1-800-532-2227 toll free

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www.dhhs.ne.gov/womenshealth web

dhhs.everywomanmatters@nebraska.gov email

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NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES