



STATE PAP PLUS

Client Enrollment & Screening

EVERY WOMAN MATTERS

Who can participate?

The State Pap Plus Program is for: **NEBRASKA RESIDENTS ONLY**

Ages 18+:

- STD Screening Only: Office visit **only** covered for Women and Men

Ages 21-29:


- Office Visit
- Cervical Cancer Screening: Cytology every 3 years per USPSTF Guidelines

Ages 30-34:

- Office Visit
- Cervical Cancer Screening: Cytology every 3 years or co-testing (cytology/HPV testing) every 5 years per USPSTF Guidelines

If client 35 or OLDER and receiving Pap, enroll using HLQ: <https://cip-dhhs.ne.gov/redcap/surveys/?s=EXYY8PJF99>
Version: Jan 2024

State Pap Plus Program Enrollment

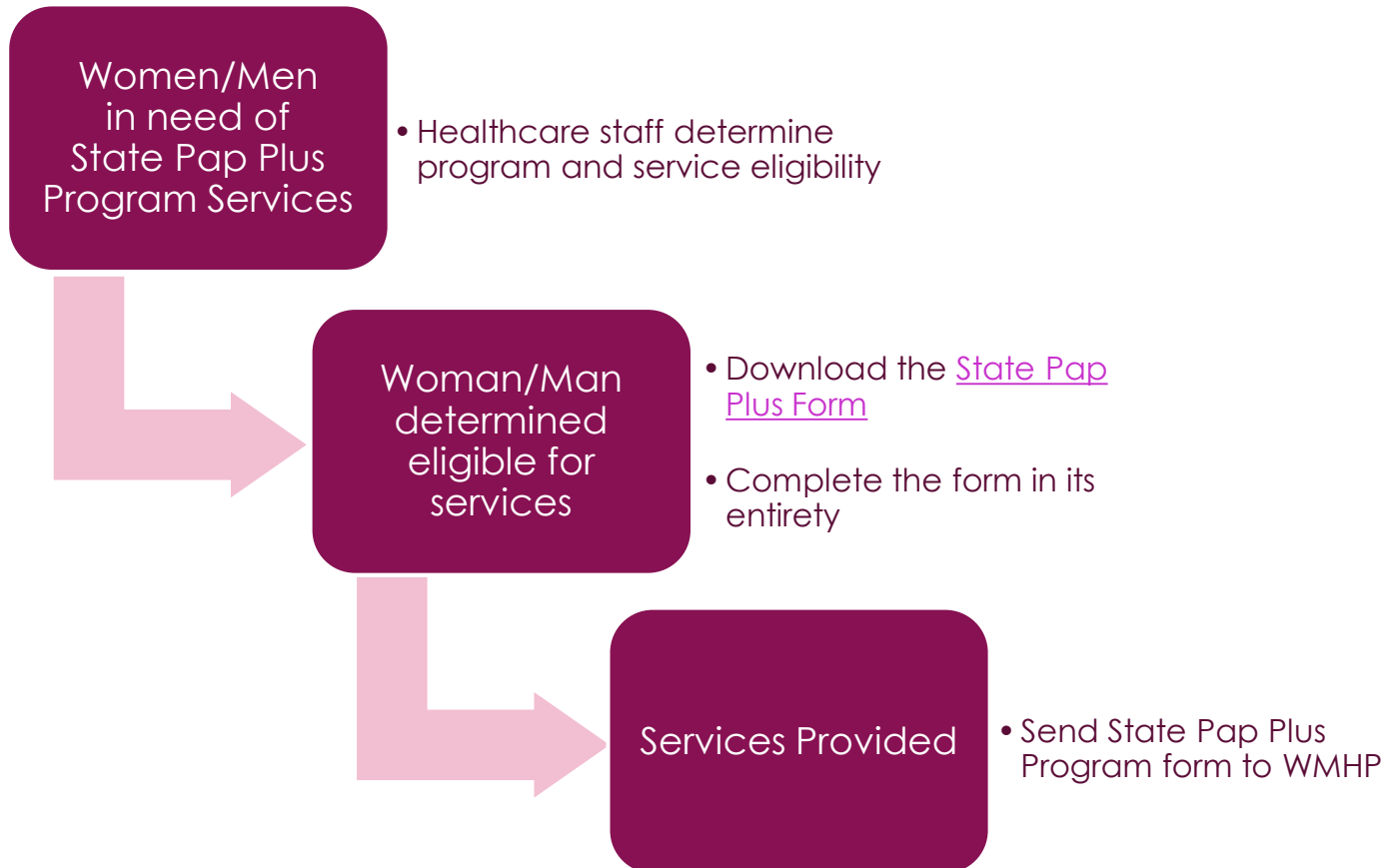


****FOR NEBRASKA RESIDENTS ONLY****
 Ages 18+: STD Screening Only - Office visit only covered for Women and Men
 Ages 21-29: Cervical Cancer Screening Cytology every 3 years per USPSTF Guidelines
 Ages 30-34: Cervical Cancer Screening cytology every 3 years or co-testing (cytology/HPV testing) every 5 years per USPSTF Guidelines

First Name:		Middle Initial:	Last Name:	
Maiden Name:		Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed		
Birthdate: ____/____/____		Gender: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Transgender <input type="radio"/> Female to Male <input type="radio"/> Male to Female		Do you identify as: <input type="radio"/> Heterosexual <input type="radio"/> Lesbian <input type="radio"/> Bisexual <input type="radio"/> Gay
Social Security #: _____			Birth Place: City and State or Country of Birth	
Address:				Apt. #:
City:		County:	State:	Zip:
Preferred way of contact:	<input type="radio"/> Home (____) (____) (____) <input type="radio"/> Work (____) (____) (____) <input type="radio"/> Cell (____) (____) (____)		Best time to reach you? <input type="radio"/> AM <input type="radio"/> PM <input type="radio"/> Yes, it is okay to text my cell phone.	
<input type="radio"/> Yes, I want to receive program information by email. My email is: _____				
DEMOGRAPHICS				
In case we can't reach you:				
Contact person:		Phone: (____) (____) (____) <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell	Relationship: <input type="radio"/> Spouse <input type="radio"/> Family/Friend <input type="radio"/> Other _____	
Are you of Hispanic/Latina(o) origin?			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
What is your primary language spoken in your home?			<input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Vietnamese <input type="radio"/> Other _____	
What race or ethnicity are you? <i>(check all boxes that apply)</i>		<input type="radio"/> American Indian/Alaska Native Tribe _____ <input type="radio"/> Black/African American <input type="radio"/> Mexican American <input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> Pacific Islander/Native Hawaiian <input type="radio"/> Other _____ <input type="radio"/> Unknown		
Are you a Refugee? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		If yes, where from: _____		
Highest level of education completed:		<input type="radio"/> <9th grade <input type="radio"/> Some high school <input type="radio"/> High school graduate or equivalent <input type="radio"/> Some college or higher <input type="radio"/> Don't know		
How did you hear about the program:		<input type="radio"/> Doctor/Clinic <input type="radio"/> Family/Friend <input type="radio"/> Agency <input type="radio"/> Newspaper/Radio/TV <input type="radio"/> I am a Current/Previous Client <input type="radio"/> Community Health Worker <input type="radio"/> Other _____		
INCOME & INSURANCE				
I may 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 for services received.				
What is your household income before taxes?		<input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly		Income: \$ _____
Please Note: - Self employed are to use net income after taxes. - If you do not have any income, please write 00 in the income space.			Forms will be returned if the income space is left blank.	
How many people live on this income?		<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12		
Do you have insurance? <input type="radio"/> Yes <input type="radio"/> No		If yes, is it:		<input type="radio"/> Medicare (for people 65 and over) <input type="radio"/> Part A and B <input type="radio"/> Part A only <input type="radio"/> Medicaid (full coverage for self) <input type="radio"/> Catastrophic Insurance Only <input type="radio"/> Private Insurance with or without Medicaid Supplement <i>(please list)</i> _____

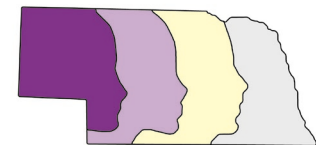
Continue to Page 2 → → →

State Pap Plus Process Overview



Program Eligibility

Every Woman Matters



Determining eligibility



It is the **provider's responsibility** to make sure that the client is eligible for program services.

This allows clients to be seen at the time of their enrollment in the State Pap Plus Program.

The following guidance will help you down the road of presumptive eligibility...

Who is Eligible



Uninsured Clients
ages 18+



United States
Residents



Income Eligible

Who is Eligible – Uninsured Clients



Uninsured Clients
ages 18+

Clients with Private Health Insurance or Medicaid are **not eligible** for screening services if their coverage includes preventive services.

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

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?

US Preventive Services Task Force (USPSTF) Guidelines:

- It is now recommended that cervical cancer screening begin at 21 years of age, regardless of sexual activity or other risk factors.
- Screening with cytology is recommended every 3 years for women 21-29 years of age.
- Clients 30-65 years of age only eligible for Pap test every THREE years with cytology or every FIVE years with co-testing (cytology/HPV).

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

State Pap Plus Screening Visit



Screening Visit

A State Pap Plus Screening Covers:

- Office visit with screening Pap Tests for women 21-29 years of age **every 3 years** with cytology
- Office visit with screening Pap Tests for women 30-34 years of age **every 3 years** with cytology or **every 5 years** with cytology/HPV co-testing (35-74 are eligible for EWM)
- Office visit covered for women AND men ages 18+ for STD screening (chlamydia, gonorrhea, syphilis) as needed

If the client is having an issue that warrants more testing and/or evaluation, diagnostic enrollment may be more appropriate.

State Pap Plus Screening Visit

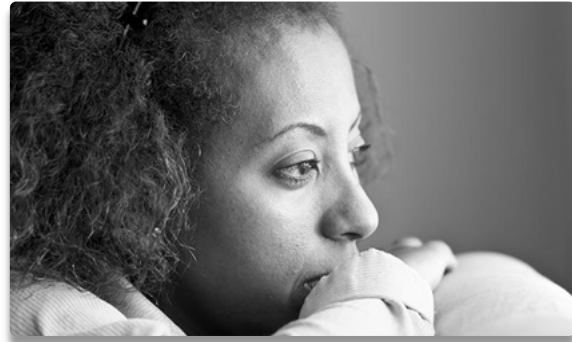


Screening Visit

A State Pap Plus Screening Covers *(con't)*:

- Clients are also eligible for:
 - Clinical Breast Exam (if abnormal, client may be eligible for Breast Diagnostic Follow Up)
 - 2 Blood Pressure Screenings
 - Height/Weight
 - Referral to Nebraska Quitline (if tobacco user)

Determining Eligibility – Personal History



Personal History

Does the client have a personal history of cancer?

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

State Pap Plus Forms

All things
State Pap Plus
Program can
be found here

Forms may be
downloaded at:

www.dhhs.ne.gov/ewmforms

dhhs.ne.gov/Pages/EWM-Provider-Information.aspx

Good Life. Great Mission.

Administration & Support | Divisions & Offices | Licensing & Regulations | Assistance Programs | Children, Families & Seniors | Public Data | Health & Wellness | Vital Records

Provider Information & Forms

Subscribe For Updates

Contracted Provider (doctors and clinic) Listing

Every Woman Matters Enrollment Age and Income Guidelines Update:
Starting November 1, 2023, Every Woman Matters has changed its enrollment age from 40 years of age to 35. It has also increased the Federal Poverty Income Guidelines from 225% to 250%.

Back to Women's and Men's Health

More

- Every Woman Matters
- Colon Cancer Awareness & Prevention
- Provider Information & Forms**
- Prevention in Communities

Diagnostic Enrollment/Follow-Up and Treatment Forms

Client Informed Refusal Form

State Pap Plus Program Forms

- English
- Spanish

Claim and Payment Status Forms and Policy

Nebraska Colon Cancer Program Data Entry Instructions for the Lab

Healthy Behavior Support Services

State Pap Plus Forms - Provider Responsibility

Version: Jan 2024

State Pap Plus Program Services

<p>STD Test(s)</p> <p>Client is 18+ <i>*Office visit ONLY covered when an STD test is performed for men and women 18+*</i></p> <p>Test(s):</p> <p><input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis</p> <p>Is this a Pelvic Inflammatory Disease (PID)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Screening Pap</p> <p>Client is 21-34 years of age: <input type="checkbox"/> Screening Pap test performed every 3 years</p> <p>Client is 30-34 years of age: <input type="checkbox"/> Screening Pap and HPV co-testing every 5 years</p> <p>Pelvic Exam</p> <p>Mark finding: <input type="checkbox"/> Negative/Benign <input type="checkbox"/> Visible Suspicious CERVICAL lesion <input type="checkbox"/> Not Performed</p> <p><input type="checkbox"/> Follow-Up Pap per current ASCCP guidelines</p>
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US Preventive Services Task Force (USPSTF) Current Guidelines:

- It is now recommended that cervical cancer screening begin at 21 years of age, regardless of sexual activity or other risk factors.
- Screening with cytology is recommended every 3 years for women 21-29 years of age.
- Clients 30-65 years of age only eligible for Pap test every THREE years with cytology or every FIVE years with co-testing (cytology/HPV).

The office visit reimbursement allows for breast screening and general clinical services to be provided at the same time as STD or Pap test, however, a client cannot enroll just to receive these services.

Client Name: _____ Please write full name - do not abbreviate

Clinic Name: _____

Date of Service for Office Visit: _____

City: _____

Quick Claim Section

Quick Claims will be entered for all State Pap Plus Enrollments and processed at the current fiscal year rates for EWM. Enrollments will be returned to the clinic if quick claim information is not filled out. Paper claims will not be accepted for State Pap Plus clients.

Quick Claim

Patient Acct. Number: _____

Check One:

STD Office Visit Only
 New Patient Office Visit
 Established Patient Office Visit

HPV Vaccination

How many previous doses of HPV vaccine has the client received? 0 1 2 3

Did the clinician recommend the client receive a dose of HPV vaccine? (if appropriate) Yes No

Did the client receive a dose of HPV vaccine at this visit? Yes No

If not, why?
 Unneeded
 Refused
 Scheduled a separate visit
 Other _____

Clinical Breast Exam

Mark if:
 Client reports breast symptoms

Mark finding:
 Negative/Benign
 Suspicious for BREAST Malignancy
Immediate follow up is required beyond diagnostic mammogram
 Not Performed

General Clinical Services

Height: (with shoes off) _____ ft./in. Refused

Weight: _____ lbs. Refused

Waist Circumference: _____ inches Refused

Note—2 blood pressure readings are required for this visit.

Blood Pressure (1): _____ mm Hg Refused

Blood Pressure (2): _____ mm Hg Refused

Is client a smoker? Yes No

Client Referred to Statewide Quitline at 1-800-QUIT-NOW
 Fax Referral to Statewide Quitline at 1-800-QUIT-NOW
 Discussed with Client and Client Refused

The provider should complete:

- All screening sections applicable on page 5
- Clinician information
- Date of Service
- Quick Claim Section

Note: State Pap + paperwork must be submitted within 60 days to be reimbursed for services

Pap/HPV Reports must be submitted at same time as State Pap+ Enrollment paperwork (***Per March 2023 Policy:** see page 81 of the [Every Woman Matters and Nebraska Colon Cancer Program Provider Participation Manual](#))

State Pap Plus Forms - Provider Responsibility



The following should be returned to EWM within **two weeks** of service:

- State Pap Plus Form
- Copy of Permanent Resident Card *(if applicable)*
- Pap and/or HPV Report

Frequently Asked Questions



State Pap Plus FAQ

- ▶ **Can the client fill out the form at the time of their office visit or does he/she need to be enrolled ahead of time?**

The client can fill out the form at the time of the office visit or they can fill out the enrollment ahead of time. It is up to the provider office. As long as the client meets eligibility requirements they are able to be seen immediately.

- ▶ **Does EWM pay for STD screening?**

EWM does not pay for STD screening. The State Pap+ Program will pay for the office visit for STD screening.

- ▶ **What if the clients cervical/breast screening has an abnormal result?**

Additional testing may be covered per ASCCP Consensus Guidelines and NCCN Clinical Practice Guidelines. See [Provider Participation Manual](#) for details.

Every Woman Matters



Additional Questions regarding the State Pap Plus Program?

Contact an Every Woman Matters representative:

Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/womenshealth web

dhhs.ewm@nebraska.gov email

Every Woman Matters



NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES