INSTRUCTIONS: Please answer each question and PRINT clearly!

Version: Nov 2019

State Pap Plus Program Enrollment

NEBRASKA
Good Life. Great Mission.
DEPT OF HEALTH AND HUMAN SERVICES

301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth

****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 30-39:
- Cervical Cancer Screening cytology every 3 years or co-testing (cytology/HPV testing) every 5 years per USPSTF Guidelines

DEMOGRAPHICS

First Name:	Middle Initial:	Last Name:	
Maiden Name:		Marital Status: ❍Single ❍Divorced ❍Married ❍Widowed	
Birthdate: month / day / year		Gender: ❍Female ❍Male	
Social Security #: _____-_____-_____		Birth Place:	
Address:			Apt. #:
City:	County:	State: City and State or Country of Birth	Zip:
Preferred way of contact:	❍Home (_____)_____ ❍Work (_____)_____ ❍Cell (_____)_____		
❍ **Yes,** I want to receive program information by email. My email is:			
In case we can't reach you:			
Contact person:	Phone: (_____)_____	Relationship: ❍Spouse ❍Family/Friend ❍Other _____	
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
How did you **hear about the program**:	❍Doctor/Clinic ❍Family/Friend ❍Agency ❍Newspaper/Radio/TV ❍I am a Current/Previous Client ❍Community Health Worker ❍Other _____

INCOME & INSURANCE

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 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. - If you do not have any income, please write $0 in the income space.			**Forms will be returned if the income space is left blank.**
How many **people** live on this income?		❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10 ❍11 ❍12	
Do you have **insurance**?	❍Yes ❍No	If **yes**, is it:	❍Medicare (for people 65 and over) ❍Part A and B ❍Part A only ❍Medicaid (full coverage for self) ❍Private Insurance with or without Medicaid Supplement ***(please list)***_____

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Informed Consent and Release of Medical Information

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- **You must read and sign page 2**

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- I want to be a part of the **Women's and Men's Health State Pap Plus Program.** I know:
  - The State Pap Plus Program pays for the cost of an office visit in which STD testing is done. It does not pay for the cost of STD testing and handling, follow up or treatment
  - I cannot be over income guidelines
  - I cannot have insurance, Medicare Part B, Medicaid Full Coverage, or an HMO
  - I will notify the State Pap Plus Program if I do not wish to be a part of this program anymore

- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the program.

- I have talked with my healthcare provider about the test(s) and understand possible side effects or discomforts.

- 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 the program, 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.

- I understand that if my breast and cervical test results are abnormal that I will automatically be enrolled in the Every Woman Matters (EWM) Diagnostic Program in order to assist me in paying for diagnostic procedures that are allowed under EWM.

- I understand that the services provided adhere to national guidelines and recommendations for cervical cancer screening. If I have any questions about allowable services, I will talk with my health care provider or call the program at 1-800-532-2227.

- My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and cervical cancer screening exams, follow up exams, and/or treatment to EWM.

- To assist me in making the best health care decisions, the State Pap Plus Program 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 the program. 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 the program 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.

- 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. **(example: permanent resident card)**

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 Your Name (first, middle, last)	Your Signature
month / day / year	month / day / year
Date of Your Signature	Your Date of Birth

 First Name: _____ Last Name: _____ Date of Birth: _____/_____/_____

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INSTRUCTIONS: Please answer each question and PRINT clearly!

BREAST & CERVICAL

****ONLY women need to answer the questions in this box**

1. Have you ever had any of the following tests?:			
Pap test	❍Yes ❍No ❍DK*	Most Recent Date ___/___/___	Result: ❍Normal ❍Abnormal ❍DK*
Mammogram	❍Yes ❍No ❍DK*	Most Recent Date ___/___/___	Result: ❍Normal ❍Abnormal ❍DK*
2. Have **you** ever had a **hysterectomy** *(removal of the uterus)*?			❍Yes ❍No ❍DK*
2a. Was your **hysterectomy** to treat cervical cancer?			❍Yes ❍No ❍DK*
3. Has your ***mother, sister or daughter*** ever had **breast cancer**?		❍Yes ❍No ❍DK*	
4. Have **you** ever had breast cancer?		❍Yes ❍No ❍DK*	When: _____/_____/_____
5. Have **you** ever had cervical cancer?		❍Yes ❍No ❍DK*	When: _____/_____/_____

DIET & PHYSICAL ACTIVITY

1. How much **fruit** do you eat in an average day? *(1 cup equals 1 large banana or 1 medium apple)*	_____ Cups ❍DK*
2. How many **vegetables** do you eat in an average day? *(1 cup equals 12 baby carrots or 1 ear corn)*	_____ Cups ❍DK*
3. Do you eat **fish** at least two times a week?	❍Yes ❍No ❍DK*
4. How many servings of **grain products** do you eat in a day? *(serving equals 1 slice whole wheat bread, 3 cups popped popcorn, 1/2 cup rice/pasta, 3/4 cup oatmeal)*	❍1 ❍2 ❍3 ❍4 ❍5 ❍6+ ❍DK*
4a. Of these servings, how many are **whole grain?**	❍Less than half ❍About half ❍More than half ❍DK*
5. Do you drink less than 36 ounces of **beverages with added sugars** weekly? *(3 (12 ounce) cans regular soda, juice, alcohol, specialty drinks)*	❍Yes ❍No ❍DK*
6. Are you currently watching or reducing your **sodium** or **salt** intake?	❍Yes ❍No ❍DK*
7. How many minutes of **physical activity** do you get in a WEEK? *(walking/running, aerobic dancing, water aerobics, general gardening, bicycling)*	_____ Minutes ❍DK*

	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	DIABETES
1. Has your doctor, nurse or other health professional **EVER** told you that you have:	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*
2. Do you take any medication prescribed by your doctors **NOW** to lower:	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*
3. During the **past 7 days**, how many days *(including today)* did you take your medication as prescribed:	_____ Days ❍DK*	_____ Days ❍DK*	_____ Days ❍DK*
4. On days you **did not take your medication** as prescribed, please tell us why:	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to Take Meds ❍Other_____	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to Take Meds ❍Other_____	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to Take Meds ❍Other_____
5. Do you check your **BLOOD PRESSURE** when you are not at the doctor's office *(at home, at pharmacy, or at a store, etc.)*?	❍Yes ❍No ❍DK*		
5a. If no, provide reason:	❍No, never told to check ❍No, don't know how to check ❍No, don't have equipment		
5b. If yes, how often do you check your **BLOOD PRESSURE**:	❍Multiple times a day ❍Daily ❍Weekly ❍A few times per week ❍Monthly ❍DK*		
5c. If yes, do you share your **BLOOD PRESSURE** numbers with your doctor that you take at home, the pharmacy or a store?	❍Yes ❍No ❍DK*		

First Name: _____ Last Name: _____ Date of Birth: _____/_____/_____

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HEART	1. Have you been **diagnosed** by a healthcare provider as having **any** of these conditions: *(mark all that apply)*	
	Coronary Heart Disease/Chest Pain:	❍Yes ❍No ❍DK*
	Congenital Heart Defects:	❍Yes ❍No ❍DK*
	Heart Failure:	❍Yes ❍No ❍DK*
	Stroke/Transient Ischemic Attack (TIA):	❍Yes ❍No ❍DK*
	Vascular Disease:	❍Yes ❍No ❍DK*
	Heart Attack:	❍Yes ❍No ❍DK*
	2. Are you taking **aspirin daily** to help prevent a heart attack or stroke?	❍Yes ❍No ❍DK*

SMOKING	1. Do you **smoke**? Includes cigarettes, pipes, or cigars *(smoked tobacco in any form)*	❍Current Smoker ❍Quit (1-12 months ago) ❍Quit (More than 12 months) ❍Never Smoked

DAILY LIFE	1. Thinking about your **physical health**, which includes physical illness and injury, on how many days during the past **30 days** was your physical health **not good**?	_____ Days ❍DK*
	2. Thinking about your **mental health**, which includes stress, depression, and problems with emotions, on how many days during the past **30 days** was your mental health **not good**?	_____ Days ❍DK*
	3. During the past **30 days**, on about how many days did poor physical or mental health keep you from doing your **usual activities**, such as self-care, work, or recreation?	_____ Days ❍DK*
	4. Are you limited in any activities because of physical, mental or emotional problems?	❍Yes ❍No ❍DK*
	5. Do **you now have** any health problems that requires you to use **special equipment**, such as a cane, a wheelchair, a special bed or a special telephone?	❍Yes ❍No ❍DK*
	5a. If yes, what **type of disability**?	❍Emotional ❍Intellectual ❍Physical ❍Sensory
	6. Over the past 2 weeks, **how often** have you been bothered by any of the following problems: 6a. **Little interest or pleasure in doing things**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day
	6b. **Feeling down, depressed, or hopeless**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day

SAFETY & WELLNESS	1. How many days in the last week have you had a **drink containing alcohol**?	❍Never _____Days ❍DK*
	1a. On days that you had a drink containing alcohol, **how many drinks** did you have? *(one drink contains 14 grams of pure alcohol, which is found in: 12 ounces of regular beer, 5 ounces of wine or 1.5 ounces of distilled spirits)*	❍Never _____Drinks ❍DK*
	2. If you are a **woman**, how many days in the past year have you had 4 or more alcoholic drinks in a day?	❍Never _____ Days ❍NA* ❍DK*
	3. If you are a **man**, how many days in the past year have you had 5 or more alcoholic drinks in a day?	❍Never _____ Days ❍NA* ❍DK*
	4. During the past 12 months, have you had a **flu shot or flu mist**?	❍No ❍Yes ❍DK*
	4a. If not, please share why?	
	5. Have you had a **pneumonia shot**?	❍No ❍Yes ❍DK*
	6. When did you last visit a **dentist or a dental clinic** for any reason?	❍Within past year ❍Within past 2 years ❍2 or more years ago ❍Never ❍DK*

 First Name: _____ Last Name: _____ Date of Birth: _____/_____/_____

State Pap Plus Program Services

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STD Test(s)

Client is 18+

Office visit* **ONLY *covered when an STD test is performed for men and women 18+*

Test(s):
- ❑ Chlamydia
- ❑ Gonnorrhea
- ❑ Syphilis

Is this a Pelvic Inflammatory Disease (PID)?
❑ Yes ❑ No

Screening Pap

Client is 21-39 years of age:
- ❑ Screening Pap test performed every 3 years

Client is 30-39 years of age:
- ❑ Screening Pap and HPV co-testing every 5 years

Pelvic Exam

Mark finding:
- ❑ Negative/Benign
- ❑ Visible Suspicious **CERVICAL** lesion
- ❑ Not Performed

Surveillance/Follow-Up Pap

- ❑ Follow-Up Pap per current ASCCP guidelines

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).

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.

_____
Clinician Name Please write full name - do no 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 mammogram
- ❑ Not Performed

General Clinical Services

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

Weight: _____ lbs. ❑Refused

Waist Circumference: _____ inches ❑Refused

Hip 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