

Cervical Diagnostic Enrollment, Follow Up & Treatment Plan for Women 21-74

Version: June 2016

Every Woman Matters



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

PROVIDER NOTES:

- If client currently enrolled for screening services complete ONLY the name and date of birth on pages 3 and 4.

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.

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Maiden Name: _____ **Marital Status:** Single Married Divorced

Birthdate: ____/____/____ **Social Security #:** ____-____-____ **Birth place** _____

Address: _____ **City and state or country of birth** _____

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:** _____

EMERGENCY CONTACT

Contact person: _____ **Relationship:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** (____) _____ Home Work Cell

DEMOGRAPHICS

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: 1 2 3
4 5 6 7 8 9 10 11 12
13 14 15 16 16+ GED
Don't Know Don't Want to Answer

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

HEALTH HISTORY

Have you ever had any of the following tests?:

Pap test Yes No DK*
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?
No Yes DK* When: ____/____/____

Mammogram Yes No DK*
Most Recent Date ____/____/____
The result: Normal Abnormal DK*

Has your **mother, sister or daughter** ever had **breast cancer**? Yes No DK*

Have **you** ever had breast cancer?
No Yes DK* When: ____/____/____

*DK - Don't Know/Not Sure

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.

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 only
 Part A and B
 Medicaid (full coverage for self)
 Private Insurance with or without Medicaid Supplement (*please list*)

Informed Consent and Release of Medical Information

■ You must **read and sign this page** to be a part of the Every Woman Matters Program.

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
 - If I am under the age of 40, I can *only* receive breast diagnostic tests.
 - I cannot be over income guidelines
 - If I have insurance, EWM will only pay after my insurance pays
 - I must be a female (per Federal Guidelines)
 - I will notify EWM if I do not wish to be a part of this program anymore
- I know that if I am under 40 years of age, I will not be a part of EWM after I have had my breast cancer diagnostic tests.
- I know that if I am 40-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and 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.
- I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM 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, 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/or cervical cancer screening, follow up exams, diagnostic tests and/or treatment to EWM.
- To assist me in making the best health care decisions, EWM 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. 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 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.

CHECK ONE

In order to be eligible for EWM 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.

SIGN AND DATE

Please Print Your Name (first, middle, last)

Your Signature

_____/_____/_____
Date

_____/_____/_____
Your Date of Birth

Cervical Follow-Up and Treatment Plan

Women under age 40 who require cytology at 1 year as follow-up must enroll in the Nebraska State Pap Plus Program in order for this service to be covered.

Client information:	First Name	MI	Last Name	DOB
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Cervical Cancer Treatment & Referral	
Referral:	Client referred to _____ who will take over care. Clinician and clinic name and city _____
Consultation:	Consultation Date to give client options _____ Consultations can only be reimbursed if provider normally brings clients into the office for consultation.
Treatment:	Treatment regimen consists of _____ (cryotherapy, cone, LEEP, surgery, chemo, radiation, etc) Treatment date _____
Refusal:	Cancer treatment refused date _____ Client made informed decision yes/no _____ Reason for refusal: _____

Follow-up of Previous Abnormal Finding	
Age 21-24	Age 25-29
Prior history: Prior Pap test Result: <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL Date: _____ Pap ASC-H, LSIL but no CIN 2 or 3 Colposcopy/Cytology at 6 month intervals for 2 years Date _____ Results _____	Prior history: Prior Pap test: date _____ Results _____ Prior Colposcopy date: _____ Results _____ CIN 2/3 with No treatment done Colposcopy/Cytology Date _____ Results _____ If client was not previously enrolled in EWM, must provide prior Pap/colposcopy reports
Pap ASC-H, LSIL but no CIN 2 or 3 Colposcopy/Cytology at 6 month intervals for 2 years Date _____ Results _____	CIN 2/3 with no margins involved <ul style="list-style-type: none"> • Repeat co-testing at 12 & 24 months Client should get a screening card 1 year after their last abnormal Pap test.
Name of Clinic	CIN 2/3 with margins involved Colposcopy and cytology with ECC Re-evaluated at 4-6 months Date _____ Results _____ Date: _____

- Fax to 402-471-0913 or mail to Every Woman Matters, PO Box 94817 Lincoln, NE 68509-4817
- Call us with any questions at 1-800-532-2227. Print out forms online at www.dhhs.ne.gov/ewmforms

Instructions

About this form: This form is to be used only for women with an **abnormal Pap test** that are in need of further testing to diagnose whether or not cervical cancer is present.

Your client does not have to be currently enrolled in our program to use this form. This form can be used to enroll clients in Every Woman Matters to cover diagnostic testing as long as they meet our income guidelines and are US citizens or have a Permanent Residency card. Call us at 1-800-532-2227 or check our website for current income guidelines.

<http://dhhs.ne.gov/PublicHealth/EWM/Pages/Home.aspx>

Guidelines for Reimbursement: The Every Woman Matters Medical Advisory Board Recommends that we follow the 2014 ASCCP Guidelines approved by the Centers for Disease Control and Prevention (CDC). Algorithms for the ASCCP guidelines can be found at http://www.asccp.org/Portals/9/docs/ASCCP%20Management%20Guidelines_August%202014.pdf See reverse side for a table of reimbursable procedures.

What providers need to do:

Review pages 1 and 2 for completion by client

• **If not completed, the client cannot be enrolled.** If the client is currently enrolled and recently filled out a Healthy Lifestyle Questionnaire, pages 1 and 2 don't need to be completed or returned. Call if you are not sure.

Page 1 must be completed with:

- Contact information
- Demographics
- Breast and cervical history

Page 2 must be completed with:

- Income and insurance
- Citizen Status or Alien Status (client must provide a copy of their Permanent Resident Card)
- Signature (date of signature must be date of first service for it to be reimbursed)

Complete page 3

This can be filled out by any member of the health care team

• **Do NOT SUBMIT unless ALL OF THESE ITEMS ARE COMPLETE:**

- Check the box with the abnormal findings and the box indicating corresponding diagnostic procedure done and date
- Check the **final diagnosis and date of diagnosis**
- Fill in the clinic name

Attach documentation

• **Please remember to attach all clinical documentation** if appropriate (copies of breast ultrasound, diagnostic mammogram, pathology reports on biopsies). Form may be returned to you if documentation isn't included.

CRITICAL REMINDERS:

- Providers must follow current ASCCP guidelines
- Diagnostic procedures **must** correspond with screening results
- Consultation can only be reimbursed if provider normally brings clients in the office for consultation
- We only accept diagnostic forms printed July 2014 or later. Forms are available at www.dhhs.ne.gov/ewmforms.

Clients who need surveillance/follow-up from a previous abnormal Pap test:

- Follow-up is reimbursable only for clients ages 40-74
- Women under 40 should enroll in the State Pap Plus program to have Pap covered
- Client must be enrolled. Call if you are not sure.
- Pre-authorization not needed, but must follow ASCCP guidelines.
- Complete "Follow-Up of Previous Abnormal Finding" section, page 4

If client gets diagnosed with cervical cancer:

- Indicate type of treatment and where client is being referred to by completing page 4 – Cervical Cancer Referral & Treatment.
- Fill out Treatment Funds Request Form to access treatment funds
- Client may be eligible for Nebraska Medicaid for LEEP procedure or cancer treatment.

