

CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

Every Woman Matters

Rev. December 2016



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

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.

PROVIDER NOTES:

- **Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.**
- If client is currently enrolled for screening services complete **ONLY** the name and date of birth on pages 3 and 4.

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 _____
City and state or country of birth
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: _____

EMERGENCY CONTACT

Contact person: _____ Relationship: _____
Phone: (____) _____ Home Work Cell
Address: _____ City: _____ State: _____ Zip: _____

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

Finish the section below... read the consent... check a box... then sign & date and you're done!

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)

*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

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

*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

Name:	First	MI	Last	DOB
Provider information:	Screening:	Name		
	Diagnostic:	Name		
	City and Phone #		City and Phone #	
	City and Phone #		City and Phone #	

Instructions: Please send EWM this form along with Pap test and colposcopy results when diagnostic workup is complete. Must follow 2014 ASCCP guidelines.

Pap results: Find the client's Pap test result below and mark the date of service for the Pap and procedure listed directly underneath.

If your client's procedure is NOT listed directly underneath their Pap result, it may not be reimbursable by our program. Call us to discuss.

Date	ASC-US	LSIL	ASC-H	HSIL	AGC	Sq. Cell Carcinoma	
Negative	Unsatisfactory	ASC-US	LSIL	ASC-H	HSIL	AGC	Sq. Cell Carcinoma
<p>Date _____</p> <p>With cervical lesion</p> <p><input type="checkbox"/> Colposcopy with biopsy</p> <p>Date of service: _____</p> <p>HPV+ ages 30+</p> <p><input type="checkbox"/> Repeat co-testing @ 1 year (must re-enroll in State Pap Program if under 40)</p> <p><input type="checkbox"/> Colposcopy with biopsy IF HPV 16 or 18 positive</p> <p>Date of service: _____</p>	<p>Date _____</p> <p>HPV unknown or HPV-</p> <p>Repeat cytology in 2-4 months.</p> <p><i>Not eligible for colposcopy.</i></p> <p>-----</p> <p>HPV+</p> <p>Ages 21-29: Repeat cytology in 2-4 months, no HBV test allowed per guidelines</p> <p>Ages 30+ Colposcopy with biopsy</p> <p>Date of service: _____</p>	<p>Date _____</p> <p>Ages 21-24: Repeat Cytology in 12 months. Must re-enroll in the State Pap Program. <i>Not eligible for colposcopy</i></p> <p>Ages 25-74: HPV unknown: Preferred: do HPV testing Acceptable: Repeat cytology at 1 year</p> <p>HPV negative: Repeat co-testing in 3 years</p> <p>HPV positive: Colposcopy with biopsy</p> <p>Date of service: _____</p>	<p>Date _____</p> <p>Ages 21-24: Repeat Cytology in 12 months. Must re-enroll in the State Pap Program. <i>Not eligible for colposcopy</i></p> <p>Ages 25-74: HPV negative: Preferred: Repeat co-testing in 1 year Acceptable: Colposcopy</p> <p>Date of service: _____</p> <p>HPV positive or no HPV: Colposcopy</p> <p>Date of service: _____</p>	<p>Date _____</p> <p><input type="checkbox"/> Colposcopy with biopsy</p> <p>Date of service: _____</p> <p>Ages 21-24: Colposcopy with biopsy</p> <p>Date of service: _____</p> <p>Ages 25-74: Colposcopy with biopsy OR immediate LEEP</p> <p>Date of service: _____</p>	<p>Date _____</p> <p>All Subcategories:</p> <p><input type="checkbox"/> Colposcopy with biopsy + ECC and Endometrial biopsy*</p> <p>Both to be done on the same day.</p> <p>Date of Service: _____</p> <p>Atypical Endometrial Cells:</p> <p><input type="checkbox"/> Endometrial and endocervical Sampling.</p> <p>Date of Service: _____</p> <p>If no endometrial pathology:</p> <p><input type="checkbox"/> Colposcopy</p> <p>Date of Service: _____</p>	<p>Date _____</p> <p>Date</p> <p>Treatment referral to OB/GYN</p> <p>Complete page 4 – cervical cancer treatment section.</p>	

Consultation or second opinion: Physician: _____ Clinic Name: _____ Date of service: _____

*If ≥ 35 years or at risk for endometrial neoplasia. Includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.

Final Diagnosis: <small>This section must be completed before sending in.</small>	<p>Date of final diagnosis or pathology report: _____</p>	<p>Check one:</p> <p><input type="checkbox"/> Inconclusive Results</p> <p><input type="checkbox"/> Normal/Benign Inflammation</p> <p><input type="checkbox"/> HPV/Condylomata/Atypia</p> <p><input type="checkbox"/> CIN I → <input type="checkbox"/> Treatment not indicated</p>
Refusal:	<p><input type="checkbox"/> Client refused diagnostic workup</p> <p>--Did client make informed decision?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>--Initiate Client Informed Refusal Form</p>	<p><input type="checkbox"/> CIN II <input type="checkbox"/> CIN III carcinoma in situ</p> <p><input type="checkbox"/> Invasive Cancer</p> <p>For CIN II and greater, complete pg 4: Cervical Cancer Treatment and Referral</p>
Clinic Name:	Date:	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

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. <small>Clinician and clinic name and city</small>
Consultation:	Consultation Date to give client options _____ <small>Consultations can only be reimbursed if provider normally brings clients into the office for consultation.</small>
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	Age 25-74
Prior history: Prior Pap test Result: <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL Date: _____	Prior history: Prior Pap test: date _____ Results _____ Prior Colposcopy date: _____ Results _____	Prior history: Prior Pap test: date _____ Results _____ Prior Colposcopy date: _____ Results _____
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 treatment done Colposcopy/Cytology 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.
	If client was not previously enrolled in EWM, must provide prior Pap/colposcopy reports	CIN 2/3 with margins involved Colposcopy and cytology with ECC Re-evaluated at 4-6 months Date _____ Results _____
Name of Clinic	City:	Date:

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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.

