

# State Pap Plus Program

Version: November 2015

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

**\*\*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

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.

**INSTRUCTIONS: Please answer each question and PRINT clearly!**

DEMOGRAPHICS

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Marital Status:  Single  Married  Divorced

Birthdate: month / day / year Gender:  Female  Male Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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: \_\_\_\_\_ Relationship:  Spouse  Family/Friend  
Contact person: \_\_\_\_\_  Other \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_  Home  Work  Cell

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you of **Hispanic/Latina(o)** origin?  Yes  No  Unknown Country of origin: \_\_\_\_\_

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  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.

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

BREAST & CERVICAL

1. Have **you** ever had any of the **following tests**?  
**Pap test**  Yes  No  DK\* Most Recent Date \_\_\_\_/\_\_\_\_/\_\_\_\_ The result:  Normal  Abnormal  DK\*

**Mammogram** (breast x-ray)  Yes  No  DK\* Most Recent Date \_\_\_\_/\_\_\_\_/\_\_\_\_ The result:  Normal  Abnormal  DK\*

2. Have **you** ever had a **hysterectomy** (removal of the uterus)?  No  Yes  DK\*

2a. Was your **hysterectomy** to treat cervical cancer?  No  Yes  DK\*

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

4. Have **you** ever had **breast cancer**?  No  Yes  DK\* When: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Have **you** ever had **cervical cancer**?  No  Yes  DK\* When: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*DK - Don't Know/Not Sure

Continue to Page 2 → → →

# Informed Consent and Release of Medical Information Version: November 2015

■ You must read and sign page 2.

- 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
  - If I have insurance, EWM will only pay after my insurance pays
  - 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

# Client Information & Healthy Lifestyle Questionnaire

**INSTRUCTIONS: Please answer each question and PRINT clearly!**

Version: November 2015

**DIET & PHYSICAL ACTIVITY**

- How much **fruit** do you eat in an average day? *(1 cup equals 1 large banana or 1 medium apple)* \_\_\_\_\_ Cups DK\* DW\*
- How many **vegetables** do you eat in an average day? *(1 cup equals 12 baby carrots or 1 ear corn)* \_\_\_\_\_ Cups DK\* DW\*
- Do you eat 2 servings or more of **fish** weekly? *(1 serving equals 7 ounce can tuna or 1 filet pollock)* Yes No DK\* DW\*
- Do you eat 3 ounces or more of **whole grains** daily?  
*(1 ounce equals 1 serving, a serving equals 1 slice whole wheat bread, 3 cups popped popcorn)* Yes No DK\* DW\*
- 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\* DW\*
- Are you currently watching or reducing your **sodium** or **salt** intake? Yes No DK\* DW\*
- How much **moderate physical activity** do you get in a week?  
*(walking, water aerobics, general gardening, able to talk/hold conversation)* \_\_\_\_\_ Minutes DK\* DW\*
- How much **vigorous physical activity** do you get in a week?  
*(running, race-walking, aerobic dancing, bicycling, not able to talk/hold conversation)* \_\_\_\_\_ Minutes DK\* DW\*

\*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

**CHOLESTEROL**

- Do you have **high cholesterol**? Yes No DK\* DW\*  
**If no, skip to the next set of questions below (BLOOD PRESSURE)**
- Did your doctor **prescribe medication** to help lower your **cholesterol**? Yes No DK\* DW\*  
**If no, skip to the next set of questions below (BLOOD PRESSURE)**
- During the **past 7 days**, how many days (including today) did you take your medication as prescribed? \_\_\_\_\_ Days
- On days you **did not take your medication** as prescribed, please tell us why.  
Cost Forgot to take  
Side Effects Need Refill

\*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

**BLOOD PRESSURE**

- Do you have **high blood pressure**? Yes No DK\* DW\*  
**If no, skip to the next set of questions below (DIABETES)**
- Did your doctor **prescribe medication** to help lower your **blood pressure**? Yes No DK\* DW\*  
**If no, skip to the next set of questions below (DIABETES)**
- During the **past 7 days**, how many days (including today) did you take your medication as prescribed? \_\_\_\_\_ Days
- 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 \_\_\_\_\_
- Do you measure your **blood pressure** at home or using another calibrated source (like a pharmacy)? Yes No DK\* DW\*
  - If no, provide reason: No, Never told to measure No, Don't know how to measure No, Don't have equipment to measure
  - How often do you measure your **blood pressure** at home or using other calibrated sources (like a pharmacy)? Daily Weekly Monthly DK\* DW\*  
Multiple times per day A few times per week
  - Do you regularly share your blood pressure readings with a health care provider for feedback? Yes No DK\* DW\*

\*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

**DIABETES**

- Do you have **Diabetes**? (Either Type 1 or Type 2) Yes No DK\* DW\*  
**If no, skip to the next set of questions on Page 7 (HEART)**
- Did your doctor **prescribe medication** to help lower your **blood sugar (for diabetes)**? Yes No DK\* DW\*  
**If no, skip to the next set of questions on Page 7 (HEART)**
- During the **past 7 days**, how many days (including today) did you take your medication as prescribed? \_\_\_\_\_ Days
- On days you **did not take your medication** as prescribed, please tell us why. Cost Forgot to take

\*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3

# Client Information & Healthy Lifestyle Questionnaire

**INSTRUCTIONS: Please answer each question and PRINT clearly!**

Version: November 2015

## HEART

1. Have you been **diagnosed** by a healthcare provider as having any of these conditions:
- |   |   |  |                              |
|---|---|--|------------------------------|
| <input type="checkbox"/> Yes                                    | <input type="checkbox"/> No                       | <input type="checkbox"/> DK*           | <input type="checkbox"/> DW* |
| <input type="checkbox"/> coronary heart disease/chest pain      | <input type="checkbox"/> congenital heart defects | <input type="checkbox"/> heart failure |                              |
| <input type="checkbox"/> stroke/transient ischemic attack (TIA) | <input type="checkbox"/> vascular disease         | <input type="checkbox"/> heart attack  |                              |

\*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

## SMOKING STATUS

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  
 DW\*
2. Do you currently use **chewing tobacco, snuff, or snus**?
- Everyday  Some days  
 Not at all  DW\*
3. About how many hours a day, on average, are you in the same room or vehicle with another person who is **smoking**?
- \_\_\_\_\_ Hours  Less than one  
 None  DW\*

\*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

## 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\*  DW\*
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\*  DW\*
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\*  DW\*
4. Are you limited in any activities because of physical, mental or emotional problems?  Yes  No  DK\*  DW\*
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\*  DW\*
- 5a. If yes, what **type of disability**?
- Emotional  Intellectual  
 Physical  Sensory

\*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

## SAFETY & WELLNESS

1. If you are a **woman**, how many days in the past year have you had 4 or more alcoholic drinks in a day? \_\_\_\_\_ Days  Never  NA\*  DK\*  DW\*
2. If you are a **man**, how many days in the past year have you had 5 or more alcoholic drinks in a day? \_\_\_\_\_ Days  Never  NA\*  DK\*  DW\*
3. Do you **feel safe** in your current relationship?  No  Yes  NA\*  DW\*
4. Have you been hit, kicked, punched or otherwise hurt by someone **in the past year**?  No  Yes  NA\*  DW\*
5. Is there a partner from a previous relationship who is making you feel **unsafe now**?  No  Yes  NA\*  DW\*
6. How often do you use **seat belts** when you drive or ride in a car?
- Always  Nearly Always  
 Sometimes  Seldom  
 Never  DW\*
7. During the past 12 months, have you had a **flu shot or flu mist**?  No  Yes  DK\*  DW\*
- 7a. If not, please share why? \_\_\_\_\_
8. Have you had a **pneumonia shot**?  No  Yes  DK\*  DW\*
9. 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\*  DW\*
10. When did you last have your **eyes checked** by a doctor or eye care provider?
- Within past year  
 Within past 2 years  
 2 or more years ago  
 Never  DK\*  DW\*

\*NA - Not Applicable \*DK - Don't Know/Not Sure \*DW - Don't Want to Answer

4 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

# State Pap Plus Program Services

## STD Test(s)

Client is 18+

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

Test(s):

- Chlamydia
- Gonnorrhoea
- 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 (*list reason*) \_\_\_\_\_

### 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

### Was the client offered HPV vaccination?

- Yes
- No

### 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  
*(list reason)* \_\_\_\_\_

### General Clinical Services

- Height: (with shoes off) \_\_\_\_\_/\_\_\_\_ ft./in.  Refused
- Weight: \_\_\_\_\_ lbs.  Refused
- Waist Circumference: \_\_\_\_\_ inches  Refused
- Hip Circumference: \_\_\_\_\_ inches  Refused
- Blood Pressure (1): \_\_\_\_\_/\_\_\_\_ mm Hg  Refused
- Blood Pressure (2): \_\_\_\_\_/\_\_\_\_ mm Hg  Refused

*2 Blood Pressure readings **MUST** be taken at this visit.  
CDC & JNC VII Guidelines **REQUIRE 2 blood pressures***

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