EWM Diagnostic Program - Breast

-How EWM can help your clients with breast concerns

-What your office needs to do

EVERY WOMAN MATTERS

EWM Diagnostic Program - Breast

Who can enroll?*

Diagnostic Enrollment is for women with:

-breast concerns (pain, lump, etc.)

-abnormal breast exam

-abnormal screening mammogram

who are in need of further testing to diagnose whether or not breast cancer is present.

*If your client is 40 or over and has no insurance and needs a screening mammogram, please see our EWM Screening Guidelines for instructions.

Who can enroll in the EWM Diagnostic Breast Program?

EWM Breast Diagnostic Program Eligibility	
Gender:	Females only
Age:	18-64 years old
Income:	Must meet income guidelines (see slide 17 for details)
Insurance:	• **Women with insurance are eligible for the EWM Diagnostic program** (but ineligible for screening). See slide 10. • Uninsured women are eligible for the diagnostic program as well.
Citizenship:	Must be US Citizen or Permanent Resident (See slide 16)
Health Status:	Must need services to diagnose breast cancer

What services are covered?

Coverage is determined by the age of the client and the results of screening, following guidelines from the National Comprehensive Cancer Network (NCCN).

Procedures covered for women 18-39:

Screening mammogram **not covered** by EWM for women <40

Age	CBE Findings:	Diagnostic Services Allowable for Reimbursement Based on Findings:
18-29	Suspicious CBE (Consultation by surgeon preferred)	• Surgical Consultation (can only be reimbursed if provider normally brings clients in the office for consultation) • Breast Ultrasound • Fine Needle Aspiration • Breast Biopsy • Cytology of breast discharge
30-39	Suspicious CBE (Consultation by surgeon preferred)	Same as list above, can also get diagnostic mammogram

Note: Diagnostic mammogram alone does not meet clinical standards of care for those with a suspicious clinical breast exam

Procedures Covered for women ages 40-64:

- If the client did NOT have a screening mammogram, had a breast lump or other cause for concern, see the first row ("No Screening Mammogram and Suspicious CBE").
- If she had a screening mammogram, see the column to the right of the results of the screening mammogram (BI-RADS 0-5) to determine if services are covered.

Age	Screening Mammogram Findings		Diagnostic Services Allowable for Reimbursement Based on Findings	
40-64	**No Screening Mammogram and Suspicious CBE (palpable mass, etc.)** See Diagnostic mammogram findings ->		Diagnostic mammogram **BI-RADS 0-3**	• Breast Ultrasound is required (diagnostic mammography alone misses 15-20% of translucent tumors)
			Diagnostic mammogram **BI-RADS 4, 5**	• Fine Needle Aspiration • Breast Biopsy • Consultation
	BI-RADS 0 - Needs additional imaging evaluation		• Comparison of prior films • Diagnostic mammogram • Breast Ultrasound	
	BI-RADS 1 –Negative or **BI-RADS 2** – Benign finding	CBE Negative	• Routine Screening	
		CBE Suspicious for malignancy	• Consultation (can only be reimbursed if provider normally brings clients in the office for consultation) • Breast Ultrasound • Fine Needle Aspiration • Breast Biopsy Cytology of breast discharge	
	BI-RADS 3 – Probably Benign		• Diagnostic mammogram or ultrasound at 6 months, then every 6-12 months for 2-3 years	
	BI-RADS 4 – Suspicious Abnormality or **BI-RADS 5** – Highly suggestive of malignancy		• Consultation (can only be reimbursed if provider normally brings clients in the office for consultation) • Breast Biopsy	

Services EWM does **NOT** cover

- Breast cancer treatment (more on this later)
- Anything not directly related to diagnosing breast cancer
- Elective excisional biopsies
- Non-cancerous skin lesions on breast or axillary area
- Genetic testing
- Diagnostic mammograms for women under 30
- Office visits for women under 40 who do not need further testing
- Follow-up for women under 40

Enrolling Clients

- Clients never before enrolled in EWM
- Clients already enrolled in EWM

Who can enroll clients into EWM Breast Diagnostic Program?

- **You can**! We'll show you how!
  - We call this process "enrolling clients diagnostically"
- Any EWM contracted provider can enroll clients diagnostically
- Clients do NOT have to be previously enrolled in the program

What if a client comes in with no paperwork?

- It's OK!
- Clients do not need to bring in their EWM screening card for diagnostic services
- Clients do not need to bring any paperwork at all – even if they're not enrolled yet
- You the provider can enroll her diagnostically by using Breast Diagnostic Enrollment Form

What if a client has insurance?

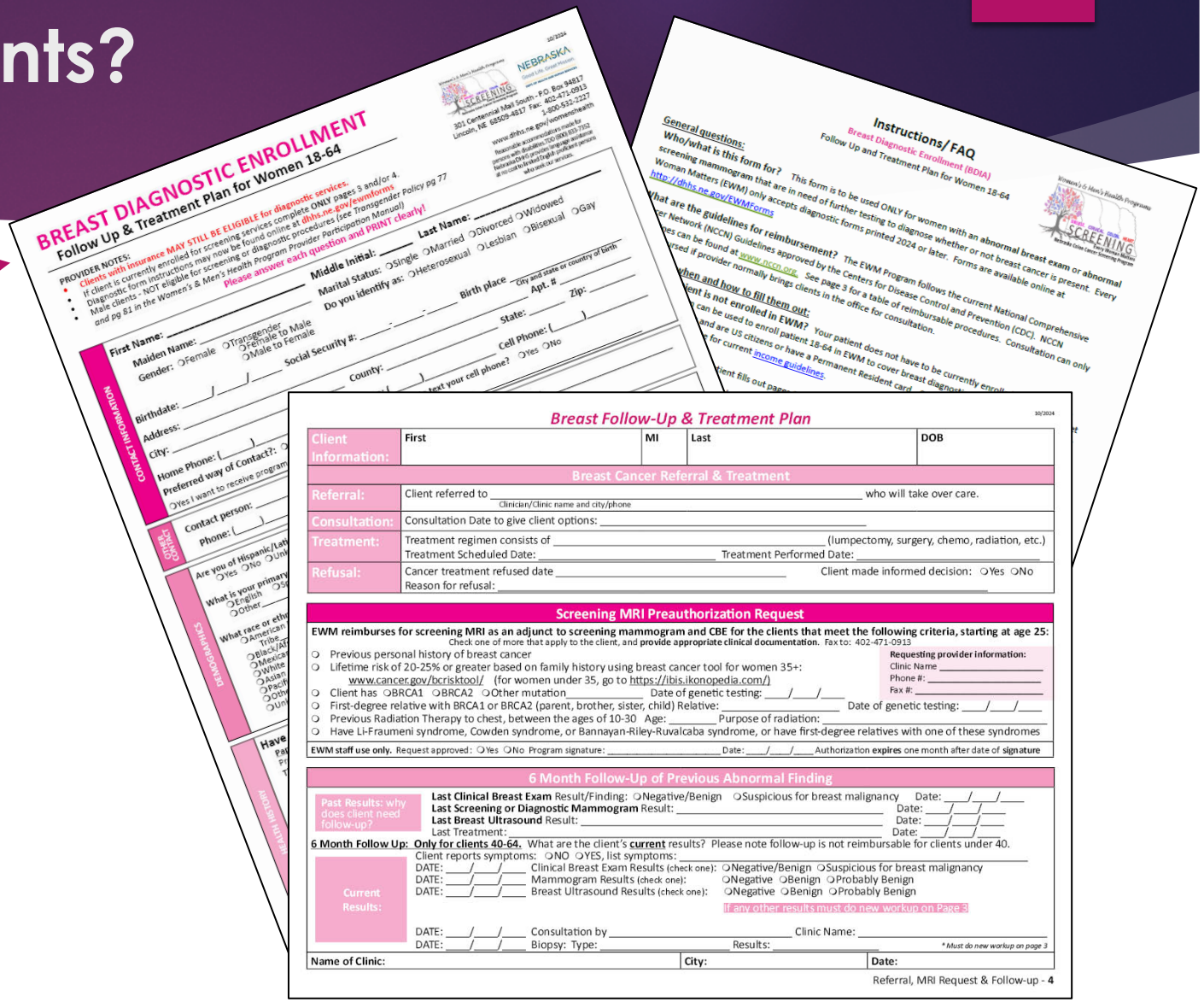
Many EWM Diagnostic clients have health insurance but still need our program to cover extra costs:

- Client is still eligible for the EWM Breast Diagnostic Program
- Must meet all other program criteria
- Is not eligible for EWM Screening Program unless insurance does not pay for preventive services
- EWM will cover costs that insurance does not pick up
- Enroll her diagnostically

Having Health Insurance is OK!

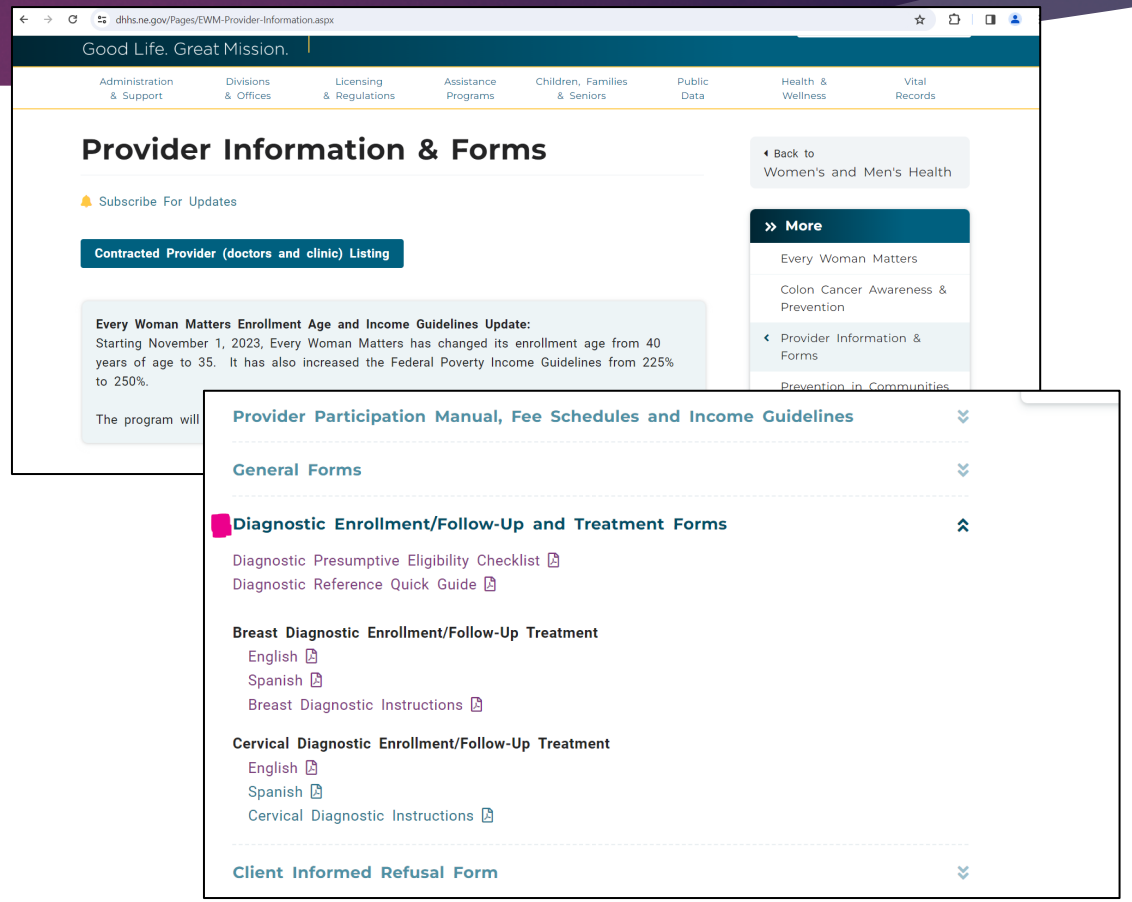
How do I enroll clients?

- Use the Breast Diagnostic Enrollment Form (BDIA)
- **Who/what is this form for?** This form is to be used ONLY for women with an **abnormal breast exam** or **abnormal screening mammogram** that are in need of further testing to diagnose whether or not breast cancer is present.

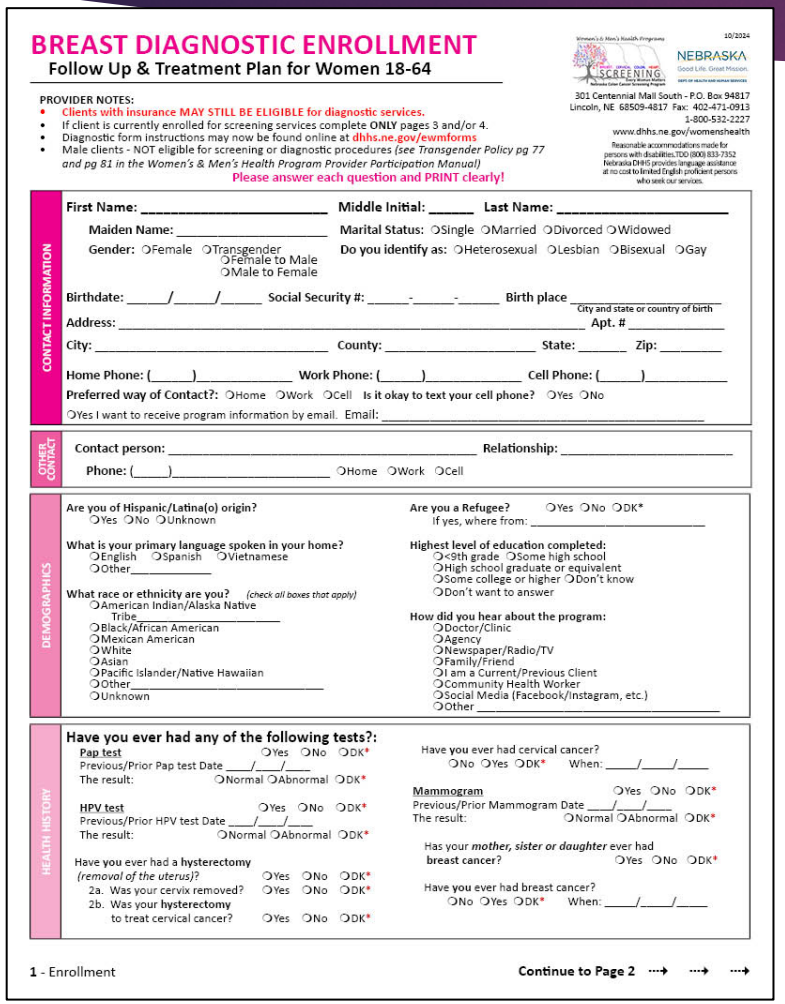


Where to find our forms

- Forms can be downloaded and printed out from here: www.dhhs.ne.gov/ewmforms
- Bookmark this page!
- Breast Diagnostic forms are available in English and Spanish
- Instructions are no longer printed as part of the form but can be found online



If you have forms in your office…



BREAST DIAGNOSTIC ENROLLMENT
Follow Up & Treatment Plan for Women 18-64

10/2024

NEBRASKA
Good Life. Great Mission.

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** pages 3 and/or 4.
- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 77 and pg 81 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed
Gender: ○Female ○Transgender ○Female to Male ○Male to Female Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay
Birthdate: ____/____/____ Social Security #: ____-____-____ Birth place _____ (City and state or country of birth)
Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____
Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No
○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____
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: ○<9th grade ○Some high school ○High school graduate or equivalent ○Some college or higher ○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 ○Social Media (Facebook/Instagram, etc.) ○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:
Pap test ○Yes ○No ○DK*
Previous/Prior Pap test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*
HPV test ○Yes ○No ○DK*
Previous/Prior HPV test 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*
Previous/Prior Mammogram 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: ____/____/____

1 - Enrollment Continue to Page 2 ⇢ ⇢ ⇢

- Please check the date in the top right corner
- We prefer forms dated 2024
- The newer the better - these forms change frequently as our program eligibility evolves
- Always go to the website for most updated version

Enrolling Clients- Part One

CLIENTS THAT ARE NOT CURRENTLY ENROLLED IN EWM

- NEVER BEEN IN EWM BEFORE

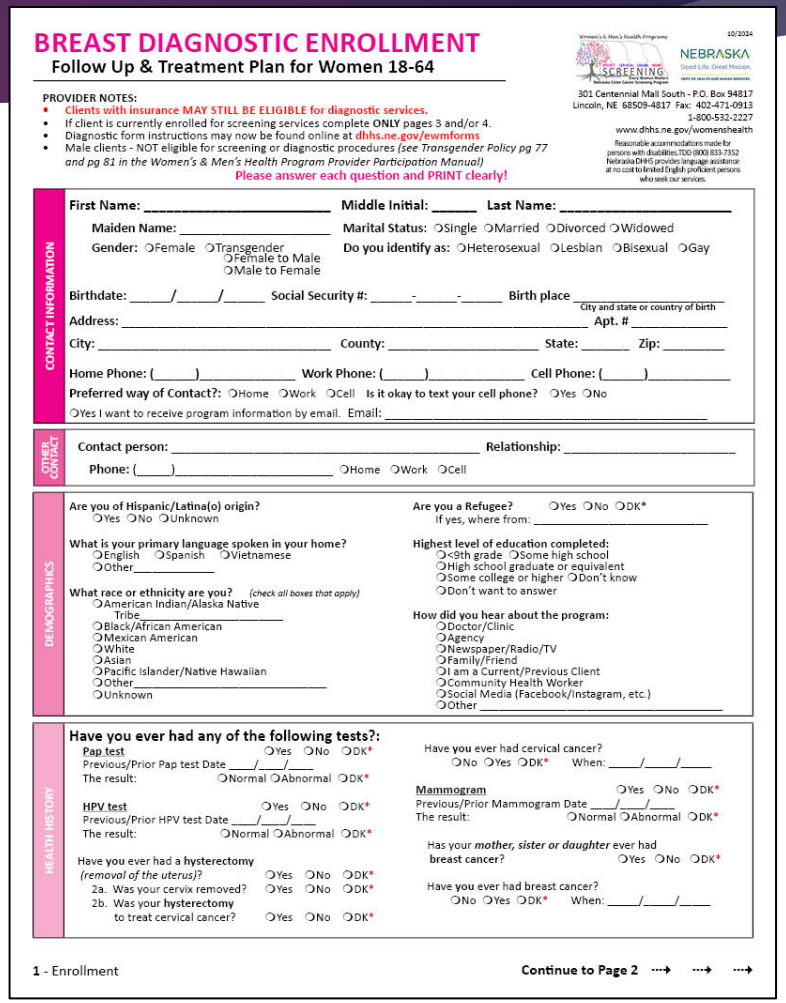
OR

- HAVE BEEN ENROLLED IN EWM OVER ONE YEAR AGO AND NEED UPDATED ENROLLMENT INFORMATION

Enrolling Clients Diagnostically
– Patients not yet enrolled in EWM

- **Your client does not have to be currently enrolled in Every Woman Matters to use the diagnostic form.**

- Clients 18-64 with a breast diagnostic issue may be enrolled immediately by using this form as long as they:
  - meet the income guidelines
  - meet citizenship requirements
  - have abnormal screening results within the last 6 months



BREAST DIAGNOSTIC ENROLLMENT
Follow Up & Treatment Plan for Women 18-64

10/2024

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1-800-532-2227
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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** pages 3 and/or 4.
- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 77 and pg 81 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed
Gender: ○Female ○Transgender ○Female to Male ○Male to Female
Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay
Birthdate: ____/____/____ Social Security #: ____-____-____ Birth place _____ (City and state or country of birth)
Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____
Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No
○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____
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:
○<9th grade ○Some high school
○High school graduate or equivalent
○Some college or higher ○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
○Social Media (Facebook/Instagram, etc.)
○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:
Pap test ○Yes ○No ○DK*
Previous/Prior Pap test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

HPV test ○Yes ○No ○DK*
Previous/Prior HPV test 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*
Previous/Prior Mammogram Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

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

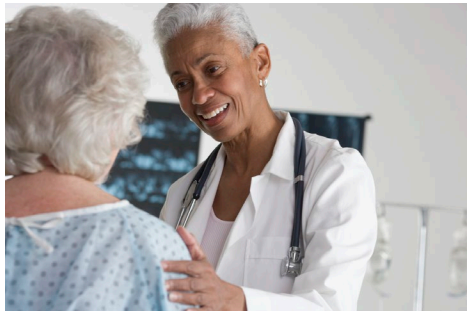
Have you ever had breast cancer? ○No ○Yes ○DK* When: ____/____/____

1 - Enrollment

Continue to Page 2 ⇢ ⇢ ⇢

Enrolling Clients Diagnostically
– Clients not yet enrolled in EWM

In order to be eligible, a client must…



Need services to diagnose breast cancer

- Breast lump, pain, or discharge
- Abnormal breast exam
- Abnormal screening results within the last 6 months.

Meet Income Guidelines

Eligible clients must be within 250% of the Federal Poverty Guidelines.

Current income guidelines can be found at https://dhhs.ne.gov/Documents/EWM_Income_Guidelines.pdf

Be a U.S. Citizen or Permanent Resident

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.

Income guidelines

Women's & Men's Health Programs

BREAST. CERVICAL. COLON. HEART.

Every Woman Matters

Nebraska Colon Cancer Screening Program

Women's and Men's Health Programs
Income Eligibility Scale
Every Woman Matters

Effective July 1, 2024-June 30, 2025

Yearly Income

# of People in Household	FREE	$5.00 Donation
1	0-$15,060	$15,061-37,650
2	0-$20,440	$20,441-51,100
3	0-$25,820	$25,821-64,550
4	0-$31,200	$31,201-78,000
5	0-$36,580	$36,581-91,450
6	0-$41,960	$41,961-104,900
7	Call 1-800-532-2227	

Monthly Income

# of People in Household	FREE	$5.00 Donation
1	0-$1,255	$1,256-3,137
2	0-$1,703	$1,704-4,257
3	0-$2,152	$2,153-5,380
4	0-$2,600	$2,601-6,500
5	0-$3,048	$3,048-7,620
6	0-$3,497	$3,498-8,742
7	Call 1-800-532-2227	

Note: *When Screening Cards are sent to clients, they will have an opportunity to make the suggested $5 donation back to the program to help women receive screening services.*

301 Centennial Mall South ~ P.O. Box 94817 ~ Lincoln, NE 68509-4817
Toll Free: 800-532-2227 ~ Local: 402-471-0929 ~ Fax: 402-471-0913
www.dhhs.ne.gov/EWM

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services.

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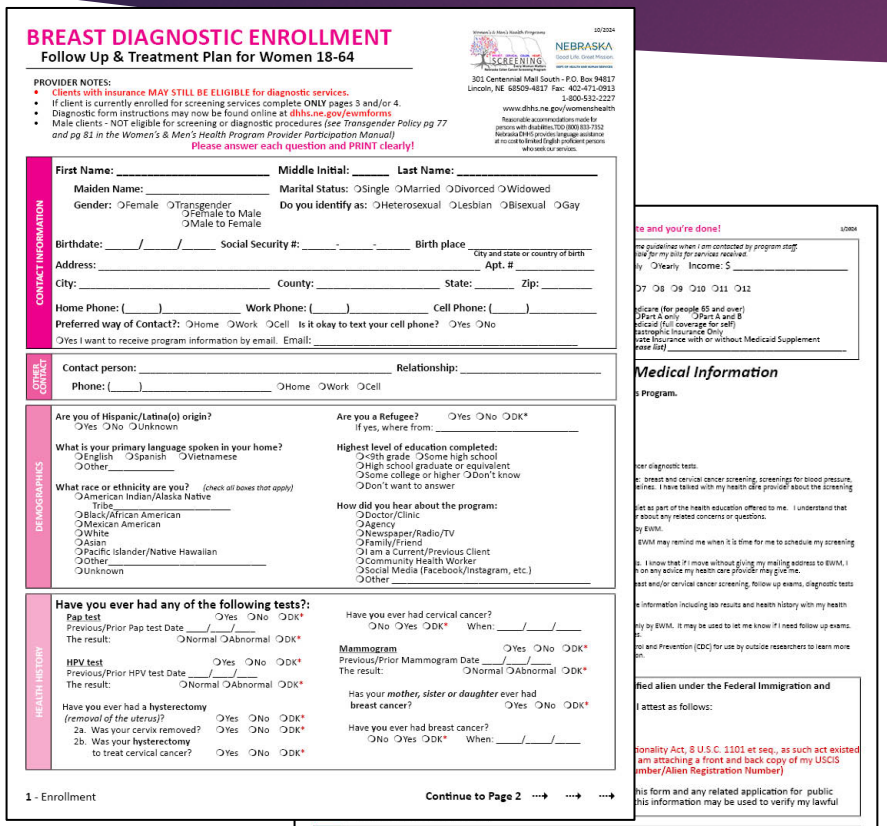
DEPT. OF HEALTH AND HUMAN SERVICES

Enrolling Clients Diagnostically

– Patients not yet enrolled in EWM



BREAST DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 18-64

10/2024

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- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 77 and pg 81 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed
Gender: ○Female ○Transgender ○Female to Male ○Male to Female Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay
Birthdate: ____/____/____ Social Security #: ___-___-___ Birth place _____ City and state or country of birth
Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____
Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No
○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____
Phone: (____)_____ ○Home ○Work ○Cell

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin? ○Yes ○No ○Unknown
Are you a Refugee? ○Yes ○No ○DK* If yes, where from: _____
What is your primary language spoken in your home? ○English ○Spanish ○Vietnamese ○Other_____
Highest level of education completed: ○<9th grade ○Some high school ○High school graduate or equivalent ○Some college or higher ○Don't know ○Don't want to answer
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
How did you hear about the program: ○Doctor/Clinic ○Agency ○Newspaper/Radio/TV ○Family/Friend ○I am a Current/Previous Client ○Community Health Worker ○Social Media (Facebook/Instagram, etc.) ○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:
Pap test ○Yes ○No ○DK* Previous/Prior Pap test Date ____/____/____ The result: ○Normal ○Abnormal ○DK*
HPV test ○Yes ○No ○DK* Previous/Prior HPV test 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* Previous/Prior Mammogram 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: ____/____/____

1 - Enrollment

Continue to Page 2 ⇢ ⇢ ⇢

te and you're done! 1/2024

me guidelines when I am contacted by program staff.
lote for my bills for services received.
ly ○Yearly Income: $ _____
○7 ○8 ○9 ○10 ○11 ○12
dicare (for people 65 and over)
○Part A only ○Part A and B
edicaid (full coverage for self)
astrophic Insurance Only
ate Insurance with or without Medicaid Supplement
ease list) _____

Medical Information

s Program.

cer diagnostic tests.
e, breast and cervical cancer screening, screenings for blood pressure, elines. I have talked with my health care provider about the screening
let as part of the health education offered to me. I understand that r about any related concerns or questions.
by EWM.
EWM may remind me when it is time for me to schedule my screening
s. I know that if I move without giving my mailing address to EWM, I on any advice my health care provider may give me.
east and/or cervical cancer screening, follow up exams, diagnostic tests
e information including lab results and health history with my health
nly by EWM. It may be used to let me know if I need follow up exams.
rol and Prevention (CDC) for use by outside researchers to learn more on.

fied alien under the Federal Immigration and
I attest as follows:
tionality Act, 8 U.S.C. 1101 et seq., as such act existed
am attaching a front and back copy of my USCIS
umber/Alien Registration Number)
his form and any related application for public
this information may be used to verify my lawful

SIGN & DATE

Please Print Your Name (first, middle, last) Your Signature
Date Your Date of Birth

Enrollment - 2

Clients who have not yet enrolled in the program or who have enrolled over one year ago must complete pages 1-2 of the Breast Diagnostic Enrollment (BDIA) with:

- contact information
- demographics
- breast and cervical history
- income and insurance
- citizenship status
- signature (date of signature should be the date of first diagnostic service in order for it to be reimbursed)

Providers can have clients complete pages 1&2 in their office.

Enrolling Clients – Part Two

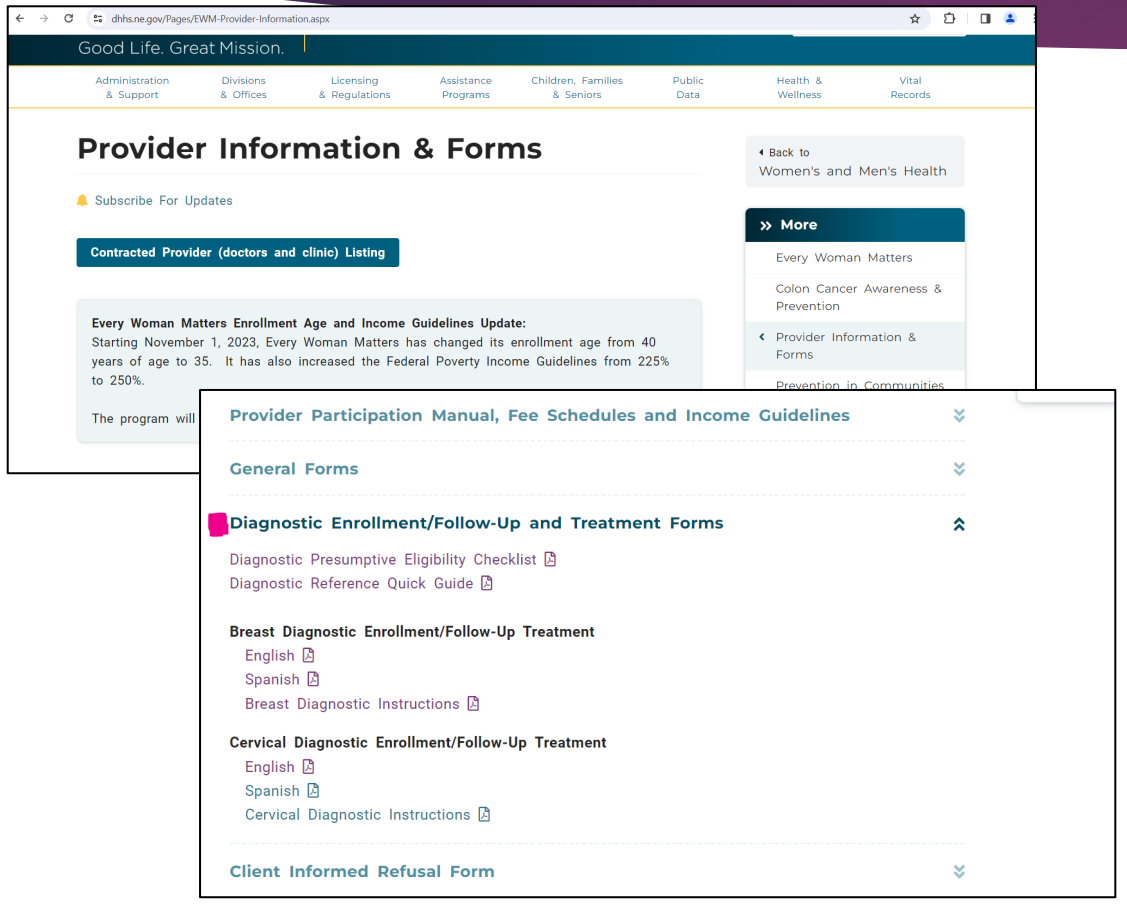
CLIENTS THAT **ARE** CURRENTLY ENROLLED IN EWM OR THE STATE PAP PLUS PROGRAM

Enrolling Clients Diagnostically
– Patients **already enrolled** in EWM

If your client meets the following criteria, pages 1-2 of the Breast Diagnostic Form (BDIA) **do not** need to be completed or returned:

- Age 21-64 and has recently completed a Healthy Lifestyle Questionnaire and had a EWM well woman screening visit
- Call EWM at 1-800-532-2227 if you are not sure they are an EWM client

NEW! Quick reference guides online!



- **When in doubt, check these out!**
- Go to www.dhhs.ne.gov/ewmforms
- There is a Checklist and a Reference Guide for eligibility for diagnostic services so you don't need to have all of this memorized
  - Diagnostic Presumptive Eligibility Checklist
  - Diagnostic Reference Quick Guide
- Print them off for your clinic

NEW - Quick reference guides

Diagnostic Presumptive Eligibility Checklist

1. Clients ages 21 and up for breast cancer diagnostics after abnormal screening results that occured within the last 6 months.
2. Clients ages 21 and up for cervical cancer diagnostics after abnormal screening results that occured within the last 6 months.
3. Clients ages 25 and over with documented personal history of BRCA1 or BRCA2 would be eligible for annual breast MRI screening.
4. Breast or Cervical Cancer Diagnostic Form completed in its entirety
   - Incomplete forms will be returned to the provider office
5. Income falls within Income Eligibility Scale
   - Eligibility scale is found on the Every Woman Matters website: https://dhhs.ne.gov/Documents/EWM_Income_Guidelines.pdf
6. Insurance coverage noted on form
   - Patient may have private insurance and be responsible for co-pays and deductibles
   - Patient cannot have Medicare part B or Medicaid
7. Client is a U.S. citizen or qualified alien under the Federal Nationality Act
   - Client has marked the box attesting that they are a US citizen or qualified alien
   - Copy of front and back of USCIS documentation provided with program form (Permanent Resident Card/Green Card)
8. Medical Release Form is signed and dated by patient (this includes client listing their date of birth and printing their name).
9. Services provided follow program guidelines
   - Guidelines are printed on Diagnostic Forms
   - Program adheres to the current ASCCP Consensus Guidelines for Cervical Abnormalities
   - Program adheres to the NCCN Screening and Diagnostic Guidelines for Breast abnormalities
10. The initial visit may be reimbursed by EWM if the provider determines that CBE is suspicious for breast malignancy and additional tests are required to reach a final diagnosis.

Women's & Men's Health Programs — BREAST. CERVICAL. COLON. HEART. SCREENING — Every Woman Matters — Nebraska Colon Cancer Screening Program

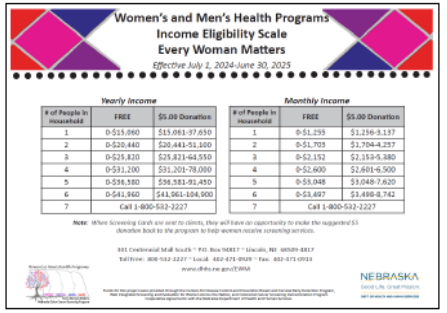
NEBRASKA — Good Life. Great Mission. — DEPT. OF HEALTH AND HUMAN SERVICES

301 Centennial Mall South || P.O. Box 94817 || Lincoln, NE 68509-4817
Toll-Free: (800) 532-2227 || **In Lincoln:** (402) 471-0929 || **Fax:** (402) 471-0913
EWM E-Mail: dhhs.ewm@nebraska.gov || Version: 10/2024

REFERENCE GUIDE FOR PROVIDERS

Qualifying Criteria Quick Guide - DIAGNOSTIC SERVICES	
Gender:	**Females Only**
Age:	**18-64* for Breast Diagnostic Services** **21-64* for Cervical Diagnostic Services** **Clients outside of age parameters who meet program guidelines and do not have Medicare coverage will be reviewed on a case by case basis. Enrollment is based upon review.*
Income:	**Must meet Income Guidelines**
Insurance:	CLIENTS MAY HAVE INSURANCE
Citizenship:	**Must be a US Citizen or Permanent Resident*** **must provide front and back copy of Permanent Resident Card/Green Card*
Health Status:	Must need services to diagnose breast or cervical cancer
Forms:	**https://dhhs.ne.gov/EWMForms** Only forms printed 2024 are accepted *(Date found in upper right-hand corner)*
Enrollment:	**BREAST** can be enrolled as a diagnostic client at the provider's office for diagnostic work up for breast issues or if they have had an abnormal screening mammogram. *Breast enrollments must follow the National Comprehensive Cancer Network (NCCN) guidelines. If a client has a suspicious clinical breast exam, a diagnostic mammogram alone does not meet clinical standards (shown on the Breast Diagnostic Enrollment Follow Up and Treatment Plan Form (BDIA)).* **CERVICAL** can be enrolled as a diagnostic client at the provider's office for diagnostic work up for abnormal pap tests. *Cervical enrollments must follow the current American Society for Colposcopy and Cervical Pathology (ASCCP) Guidelines (shown on the Cervical Diagnostic Enrollment Follow Up and Treatment Plan Form (CDIA)).*

Please call **800-532-2227** to speak with a program Nurse regarding completion of diagnostic forms or to answer diagnostic questions.


Women's and Men's Health Programs
Income Eligibility Scale
Every Woman Matters
Effective July 1, 2024-June 30, 2025

Yearly Income

# of People in Household	FREE	$5.00 Donation
1	0-$15,060	$15,061-$7,650
2	0-$20,440	$20,441-$1,100
3	0-$25,820	$25,821-$4,550
4	0-$31,200	$31,201-$8,000
5	0-$36,580	$36,581-$1,450
6	0-$41,960	$41,961-$4,900
7	Call 1-800-532-2227	

Monthly Income

# of People in Household	FREE	$5.00 Donation
1	0-$1,255	$1,256-$1,137
2	0-$1,703	$1,704-$4,257
3	0-$2,152	$2,153-$5,880
4	0-$2,600	$2,601-$6,500
5	0-$3,048	$3,048-$7,620
6	0-$3,497	$3,498-$8,742
7	Call 1-800-532-2227	

Note: Where Screening Cards are sent to clients, they will have an opportunity to make the suggested $5 donation back to the program to help women receive screening services.

301 Centennial Mall South ~ P.O. Box 94817 ~ Lincoln, NE 68509-4817
Toll Free: 800-532-2227 ~ Local: 402-471-0929 ~ Fax: 402-471-0913
www.dhhs.ne.gov/EWM

NEBRASKA
Good Life. Great Mission.

Women's & Men's Health Programs — BREAST. CERVICAL. COLON. HEART. SCREENING — Every Woman Matters — Nebraska Colon Cancer Screening Program

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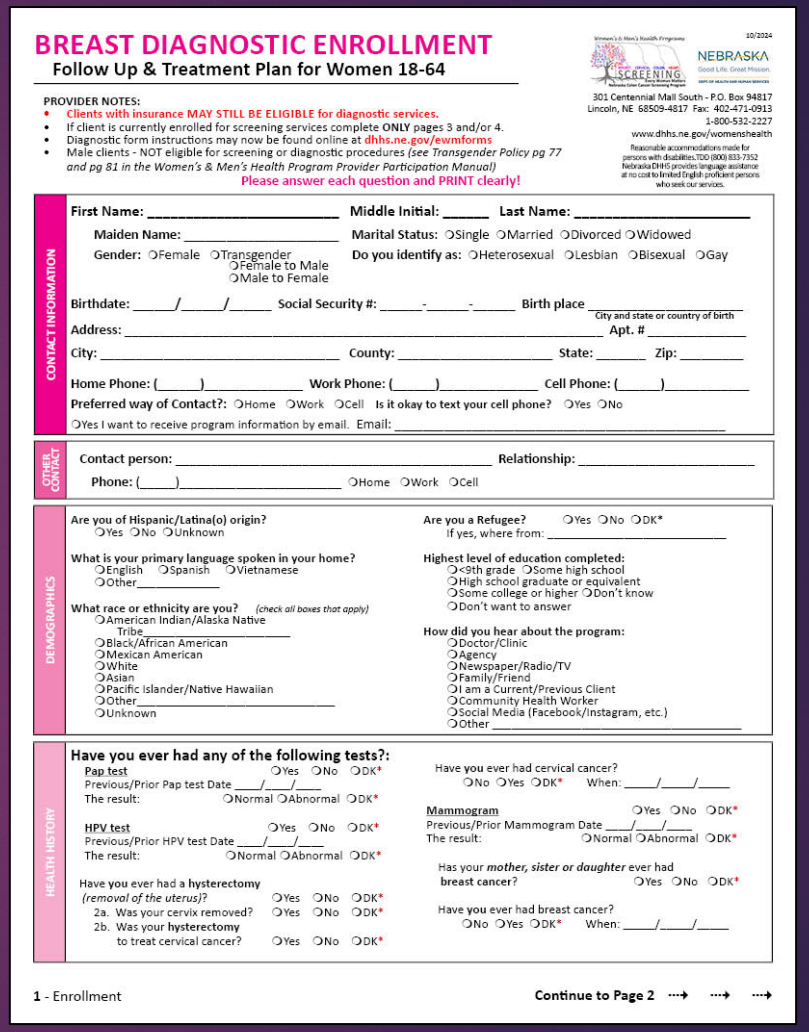
Lincoln, NE 68509
Toll Free: 800-532-2227
Fax: 402-471-0913
dhhs.ewm@nebraska.gov

10/2024

Completing Breast Diagnostic Enrollment Forms



BREAST DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 18-64

10/2024

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** pages 3 and/or 4.
- Diagnostic form instructions may now be found online at **dhhs.ne.gov/ewmforms**
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 77 and pg 81 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

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

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

Gender: ❍Female ❍Transgender ❍Female to Male ❍Male to Female **Do you identify as:** ❍Heterosexual ❍Lesbian ❍Bisexual ❍Gay

Birthdate: ____/____/____ **Social Security #:** ____-____-____ **Birth place** _____ (City and state or country of birth)

Address: _____ **Apt. #** _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

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

Preferred way of Contact?: ❍Home ❍Work ❍Cell **Is it okay to text your cell phone?** ❍Yes ❍No

❍Yes I want to receive program information by email. **Email:** _____

OTHER CONTACT

Contact person: _____ **Relationship:** _____

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:
❍<9th grade ❍Some high school
❍High school graduate or equivalent
❍Some college or higher ❍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
❍Social Media (Facebook/Instagram, etc.)
❍Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:

Pap test ❍Yes ❍No ❍DK*
Previous/Prior Pap test Date ____/____/____
The result: ❍Normal ❍Abnormal ❍DK*

HPV test ❍Yes ❍No ❍DK*
Previous/Prior HPV test 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: ____/____/____

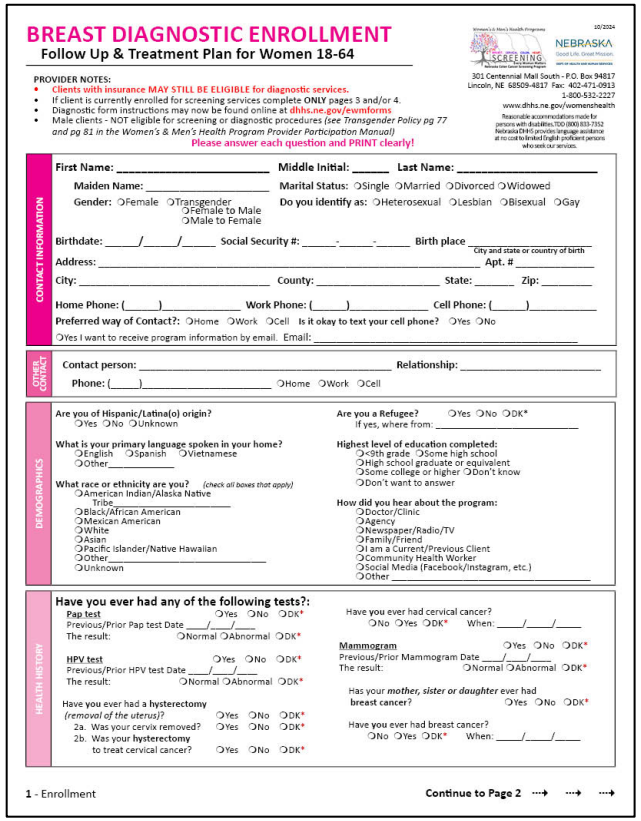
Mammogram ❍Yes ❍No ❍DK*
Previous/Prior Mammogram Date ____/____/____
The result: ❍Normal ❍Abnormal ❍DK*

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

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

First, check to make sure client filled everything out on pages 1 and 2

(for clients not already enrolled in EWM)



BREAST DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 18-64

10/2024

NEBRASKA
Good Life. Great Mission.

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 pages 3 and/or 4.
- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 77 and pg 81 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

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

Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed

Gender: ○Female ○Transgender ○Female to Male ○Male to Female ○Male to Female

Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay

Birthdate: ____/____/____ Social Security #: ____-____-____ Birth place _____ City and state or country of birth

Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No

○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____

Phone: (____)_____ ○Home ○Work ○Cell

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin? ○Yes ○No ○Unknown

Are you a Refugee? ○Yes ○No ○DK*
If yes, where from: _____

What is your primary language spoken in your home?
○English ○Spanish ○Vietnamese ○Other_____

Highest level of education completed:
○<9th grade ○Some high school ○High school graduate or equivalent ○Some college or higher ○Don't know ○Don't want to answer

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

How did you hear about the program:
○Doctor/Clinic
○Agency
○Newspaper/Radio/TV
○Family/Friend
○I am a Current/Previous Client
○Community Health Worker
○Social Media (Facebook/Instagram, etc.)
○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:

Pap test ○Yes ○No ○DK*
Previous/Prior Pap test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

HPV test ○Yes ○No ○DK*
Previous/Prior HPV test 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: ____/____/____

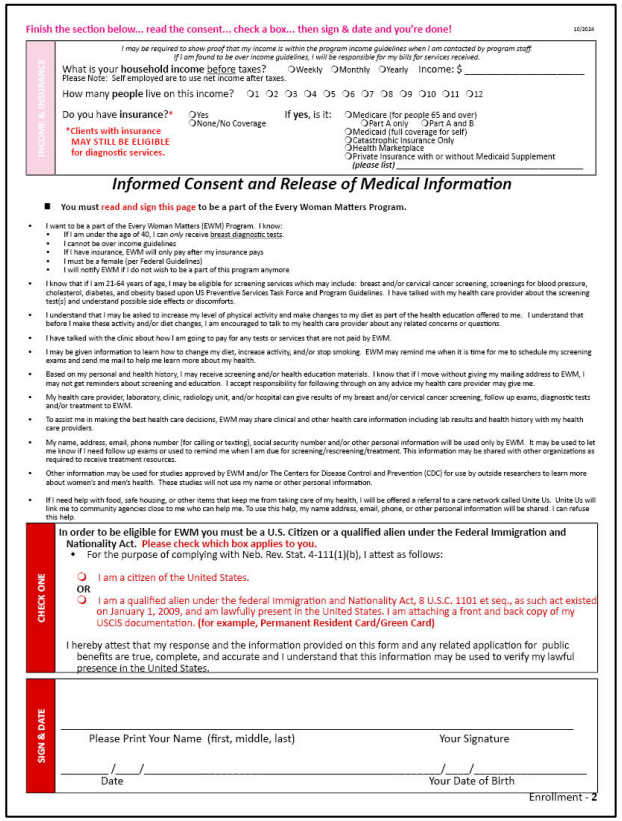
Mammogram ○Yes ○No ○DK*
Previous/Prior Mammogram Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

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

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

1 - Enrollment

Continue to Page 2 ⇢ ⇢ ⇢



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

10/2024

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? ○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) ○Catastrophic Insurance Only ○Health Marketplace ○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 21-64 years of age, I may be eligible for screening services which may include: breast and/or 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, phone number (for calling or texting), 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 or used to remind me when I am due for screening/rescreening/treatment. 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 Control and Prevention (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.
- If I need help with food, safe housing, or other items that keep me from taking care of my health, I will be offered a referral to a care network called Unite Us. Unite Us will link me to community agencies close to me who can help me. To use this help, my name address, email, phone, or other personal information will be shared. I can refuse this help.

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. 4-111(1)(b), 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, 8 U.S.C. 1101 et seq., as such act existed on January 1, 2009, and am lawfully present in the United States. I am attaching a front and back copy of my USCIS documentation. **(for example, Permanent Resident Card/Green 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.

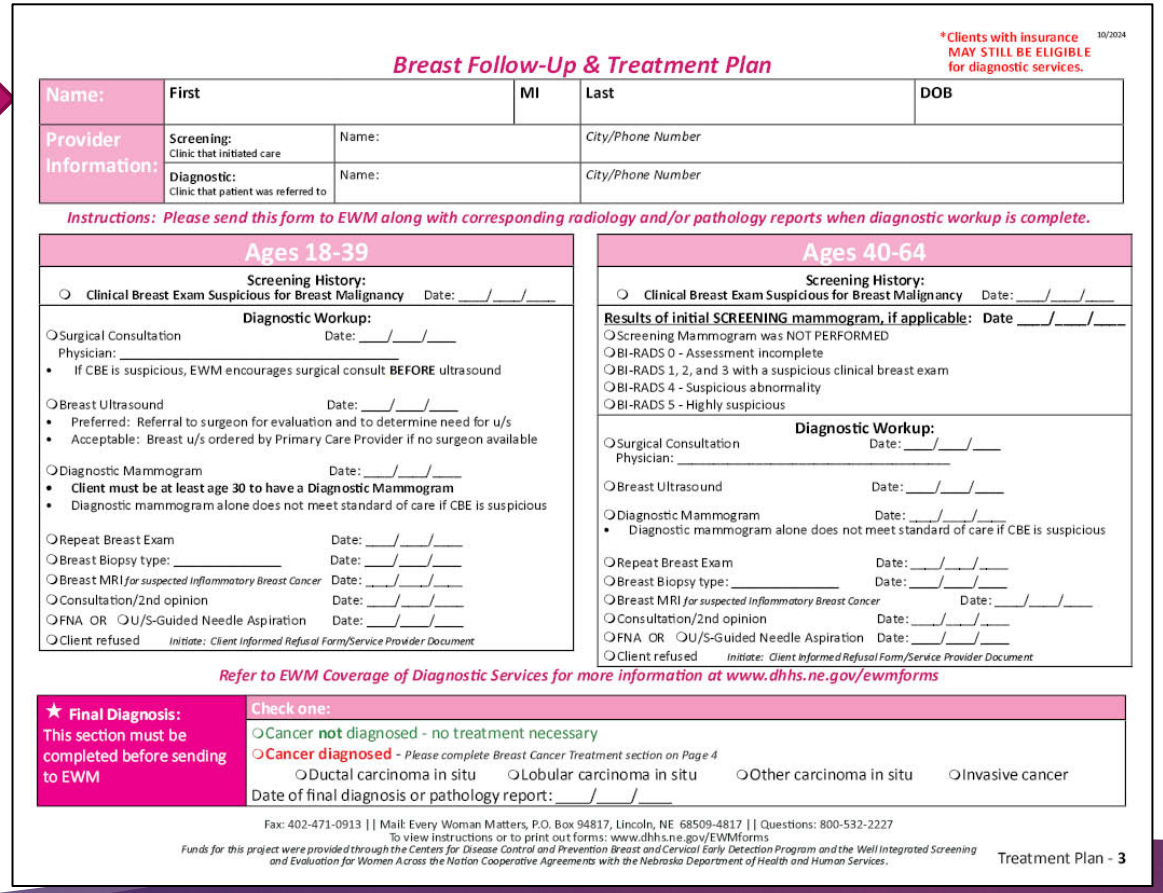
SIGN & DATE

_____
Please Print Your Name (first, middle, last) Your Signature

____/____/____ ____/____/____
Date Your Date of Birth

Enrollment - 2

- EWM will return the form to you if sections are left blank
- Income, attestation, and signature are all required
- Spanish forms available online



Breast Follow-Up & Treatment Plan

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

10/2024

Name:	First	MI	Last	DOB
Provider information:	**Screening:** Clinic that initiated care	Name:	*City/Phone Number*	
	Diagnostic: Clinic that patient was referred to	Name:	*City/Phone Number*	

Instructions: Please send this form to EWM along with corresponding radiology and/or pathology reports when diagnostic workup is complete.

Ages 18-39

Screening History:

❍ **Clinical Breast Exam Suspicious for Breast Malignancy** Date: ____/____/____

Diagnostic Workup:

❍Surgical Consultation Date: ____/____/____
Physician: _____
- If CBE is suspicious, EWM encourages surgical consult **BEFORE** ultrasound

❍Breast Ultrasound Date: ____/____/____
- Preferred: Referral to surgeon for evaluation and to determine need for u/s
- Acceptable: Breast u/s ordered by Primary Care Provider if no surgeon available

❍Diagnostic Mammogram Date: ____/____/____
- **Client must be at least age 30 to have a Diagnostic Mammogram**
- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍Repeat Breast Exam Date: ____/____/____
❍Breast Biopsy type: _____ Date: ____/____/____
❍Breast MRI *for suspected Inflammatory Breast Cancer* Date: ____/____/____
❍Consultation/2nd opinion Date: ____/____/____
❍FNA OR ❍U/S-Guided Needle Aspiration Date: ____/____/____
❍Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Ages 40-64

Screening History:

❍ **Clinical Breast Exam Suspicious for Breast Malignancy** Date: ____/____/____

Results of initial SCREENING mammogram, if applicable: Date ____/____/____
❍Screening Mammogram was NOT PERFORMED
❍BI-RADS 0 - Assessment incomplete
❍BI-RADS 1, 2, and 3 with a suspicious clinical breast exam
❍BI-RADS 4 - Suspicious abnormality
❍BI-RADS 5 - Highly suspicious

Diagnostic Workup:

❍Surgical Consultation Date: ____/____/____
Physician: _____

❍Breast Ultrasound Date: ____/____/____

❍Diagnostic Mammogram Date: ____/____/____
- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍Repeat Breast Exam Date: ____/____/____
❍Breast Biopsy type: _____ Date: ____/____/____
❍Breast MRI *for suspected Inflammatory Breast Cancer* Date: ____/____/____
❍Consultation/2nd opinion Date: ____/____/____
❍FNA OR ❍U/S-Guided Needle Aspiration Date: ____/____/____
❍Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Refer to EWM Coverage of Diagnostic Services for more information at www.dhhs.ne.gov/ewmforms

★ **Final Diagnosis:** This section must be completed before sending to EWM

Check one:

❍Cancer **not** diagnosed - no treatment necessary
❍**Cancer diagnosed** - *Please complete Breast Cancer Treatment section on Page 4*
❍Ductal carcinoma in situ ❍Lobular carcinoma in situ ❍Other carcinoma in situ ❍Invasive cancer
Date of final diagnosis or pathology report: ____/____/____

Fax: 402-471-0913 | | Mail: Every Woman Matters, P.O. Box 94817, Lincoln, NE 68509-4817 | | Questions: 800-532-2227
To view instructions or to print out forms: www.dhhs.ne.gov/EWMforms

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Treatment Plan - **3**

Complete with the client's name, DOB, and screening provider where her CBE was performed (if applicable)

Fill in your clinic's information under diagnostic provider.

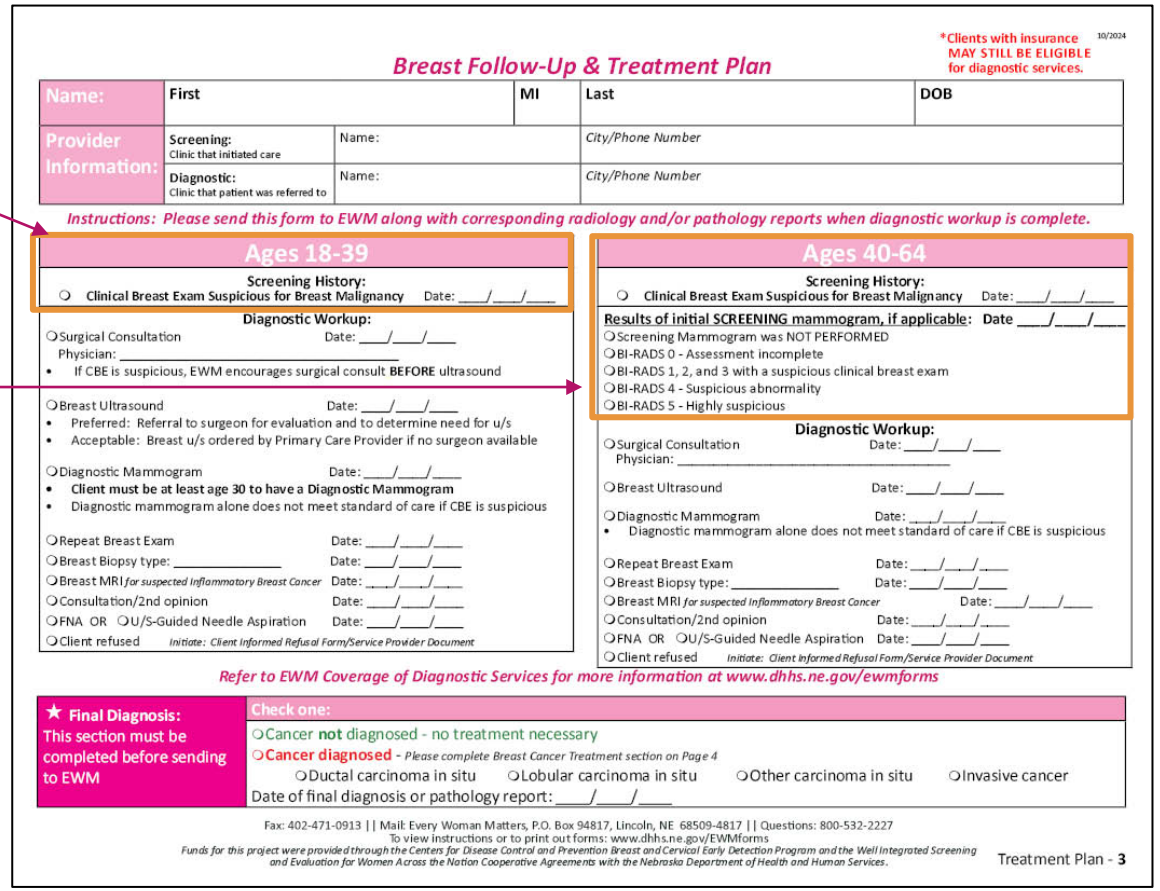
Page 3 -Let's get started!

Page 3 of the Breast Follow-up & Treatment Plan can be filled out by any member of the health care team at a primary care, OB/GYN or surgical provider's office.

Page 3 – Screening history

Screening history section:

- For patients 18-39, fill out the date and findings of her clinical breast exam.
- For patients 40-64, fill out the date and findings of clinical breast exam as well as the results of the SCREENING mammogram
  - **If client 40-64 only got diagnostic mammogram, do NOT put that in screening mammogram section**. Check the box for Screening Mammogram NOT PERFORMED and then check the box under it for Diagnostic mammogram.



*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services. 10/2024

Breast Follow-Up & Treatment Plan

Name:	First	MI	Last	DOB
Provider Information:	Screening: Clinic that initiated care	Name:	City/Phone Number	
	Diagnostic: Clinic that patient was referred to	Name:	City/Phone Number	

Instructions: Please send this form to EWM along with corresponding radiology and/or pathology reports when diagnostic workup is complete.

Ages 18-39

Screening History:
❍ Clinical Breast Exam Suspicious for Breast Malignancy Date: ___/___/___

Diagnostic Workup:
❍ Surgical Consultation Date: ___/___/___
Physician: _____
- If CBE is suspicious, EWM encourages surgical consult **BEFORE** ultrasound

❍ Breast Ultrasound Date: ___/___/___
- Preferred: Referral to surgeon for evaluation and to determine need for u/s
- Acceptable: Breast u/s ordered by Primary Care Provider if no surgeon available

❍ Diagnostic Mammogram Date: ___/___/___
- **Client must be at least age 30 to have a Diagnostic Mammogram**
- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍ Repeat Breast Exam Date: ___/___/___
❍ Breast Biopsy type: _____ Date: ___/___/___
❍ Breast MRI *for suspected Inflammatory Breast Cancer* Date: ___/___/___
❍ Consultation/2nd opinion Date: ___/___/___
❍ FNA OR ❍ U/S-Guided Needle Aspiration Date: ___/___/___
❍ Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Ages 40-64

Screening History:
❍ Clinical Breast Exam Suspicious for Breast Malignancy Date: ___/___/___

Results of initial SCREENING mammogram, if applicable: Date ___/___/___
❍ Screening Mammogram was NOT PERFORMED
❍ BI-RADS 0 - Assessment incomplete
❍ BI-RADS 1, 2, and 3 with a suspicious clinical breast exam
❍ BI-RADS 4 - Suspicious abnormality
❍ BI-RADS 5 - Highly suspicious

Diagnostic Workup:
❍ Surgical Consultation Date: ___/___/___
Physician: _____
❍ Breast Ultrasound Date: ___/___/___
❍ Diagnostic Mammogram Date: ___/___/___
- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍ Repeat Breast Exam Date: ___/___/___
❍ Breast Biopsy type: _____ Date: ___/___/___
❍ Breast MRI *for suspected Inflammatory Breast Cancer* Date: ___/___/___
❍ Consultation/2nd opinion Date: ___/___/___
❍ FNA OR ❍ U/S-Guided Needle Aspiration Date: ___/___/___
❍ Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Refer to EWM Coverage of Diagnostic Services for more information at www.dhhs.ne.gov/ewmforms

★ **Final Diagnosis:** This section must be completed before sending to EWM

Check one:
❍ Cancer **not** diagnosed - no treatment necessary
❍ **Cancer diagnosed** - *Please complete Breast Cancer Treatment section on Page 4*
❍ Ductal carcinoma in situ ❍ Lobular carcinoma in situ ❍ Other carcinoma in situ ❍ Invasive cancer
Date of final diagnosis or pathology report: ___/___/___

Fax: 402-471-0913 | | Mail: Every Woman Matters, P.O. Box 94817, Lincoln, NE 68509-4817 | | Questions: 800-532-2227
To view instructions or to print out forms: www.dhhs.ne.gov/EWMforms
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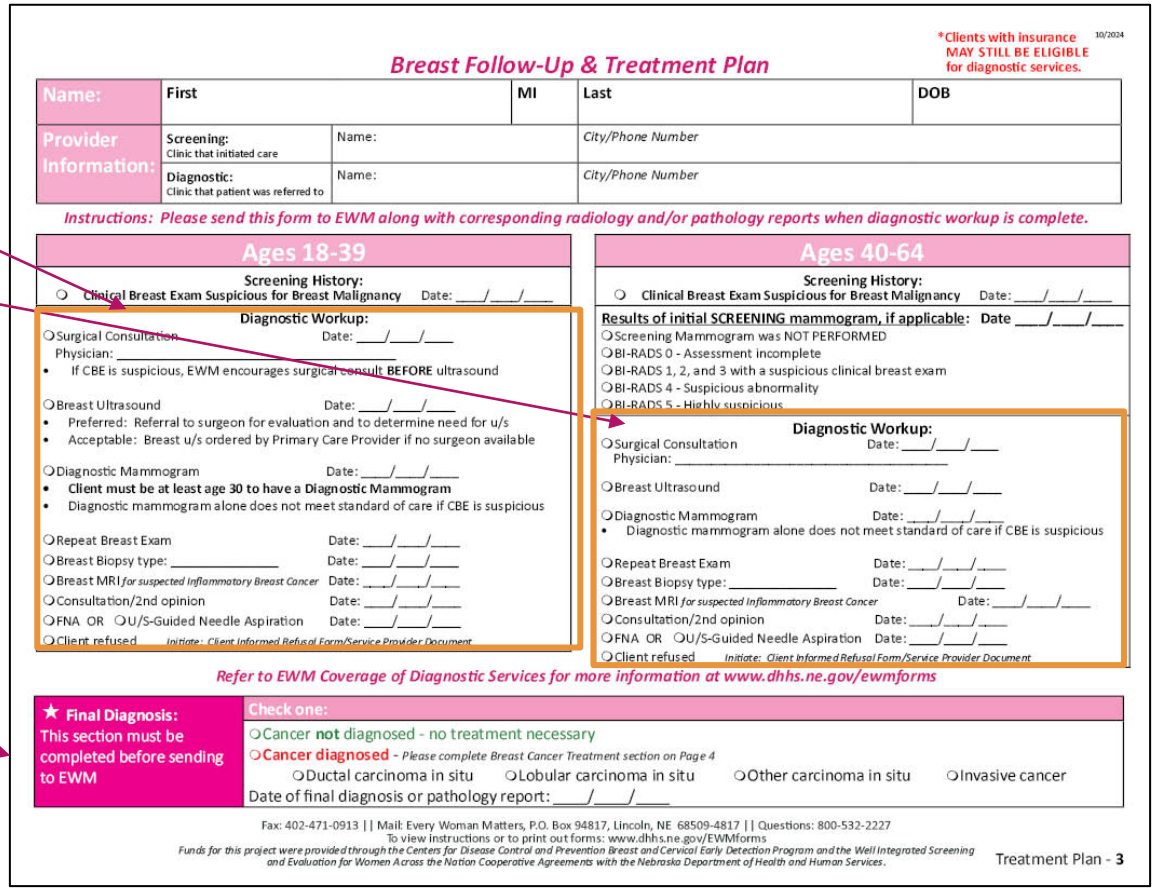
Treatment Plan - 3

Page 3 –Diagnostic workup and Final Diagnosis

- The **Diagnostic workup sections** show all of the procedures allowable for these women. Check the box with the imaging or diagnostic procedure done and fill in the date of service.
  - Send corresponding clinical documentation or form may be returned to you.
  - Submit all clinical documentation including the enrollment within 2 weeks of service.
- Check the **final diagnosis and date of diagnosis.**
  - If you do not check a final diagnosis, the form may be returned.



*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services. 10/2024

Breast Follow-Up & Treatment Plan

Name:	First	MI	Last	DOB
Provider Information:	Screening: Clinic that initiated care	Name:	City/Phone Number	
	Diagnostic: Clinic that patient was referred to	Name:	City/Phone Number	

Instructions: Please send this form to EWM along with corresponding radiology and/or pathology reports when diagnostic workup is complete.

Ages 18-39

Screening History:
❍ Clinical Breast Exam Suspicious for Breast Malignancy Date: ___/___/___

Diagnostic Workup:
❍ Surgical Consultation Date: ___/___/___
Physician: _____
- If CBE is suspicious, EWM encourages surgical consult **BEFORE** ultrasound

❍ Breast Ultrasound Date: ___/___/___
- Preferred: Referral to surgeon for evaluation and to determine need for u/s
- Acceptable: Breast u/s ordered by Primary Care Provider if no surgeon available

❍ Diagnostic Mammogram Date: ___/___/___
- **Client must be at least age 30 to have a Diagnostic Mammogram**
- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍ Repeat Breast Exam Date: ___/___/___
❍ Breast Biopsy type: _____ Date: ___/___/___
❍ Breast MRI *for suspected Inflammatory Breast Cancer* Date: ___/___/___
❍ Consultation/2nd opinion Date: ___/___/___
❍ FNA OR ❍ U/S-Guided Needle Aspiration Date: ___/___/___
❍ Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Ages 40-64

Screening History:
❍ Clinical Breast Exam Suspicious for Breast Malignancy Date: ___/___/___

Results of initial SCREENING mammogram, if applicable: Date ___/___/___
❍ Screening Mammogram was NOT PERFORMED
❍ BI-RADS 0 - Assessment incomplete
❍ BI-RADS 1, 2, and 3 with a suspicious clinical breast exam
❍ BI-RADS 4 - Suspicious abnormality
❍ BI-RADS 5 - Highly suspicious

Diagnostic Workup:
❍ Surgical Consultation Date: ___/___/___
Physician: _____
❍ Breast Ultrasound Date: ___/___/___
❍ Diagnostic Mammogram Date: ___/___/___
- Diagnostic mammogram alone does not meet standard of care if CBE is suspicious

❍ Repeat Breast Exam Date: ___/___/___
❍ Breast Biopsy type: _____ Date: ___/___/___
❍ Breast MRI *for suspected Inflammatory Breast Cancer* Date: ___/___/___
❍ Consultation/2nd opinion Date: ___/___/___
❍ FNA OR ❍ U/S-Guided Needle Aspiration Date: ___/___/___
❍ Client refused *Initiate: Client Informed Refusal Form/Service Provider Document*

Refer to EWM Coverage of Diagnostic Services for more information at www.dhhs.ne.gov/ewmforms

★ Final Diagnosis: This section must be completed before sending to EWM	Check one:
	❍ Cancer **not** diagnosed - no treatment necessary
	❍ **Cancer diagnosed** - *Please complete Breast Cancer Treatment section on Page 4*
	❍ Ductal carcinoma in situ ❍ Lobular carcinoma in situ ❍ Other carcinoma in situ ❍ Invasive cancer
	Date of final diagnosis or pathology report: ___/___/___

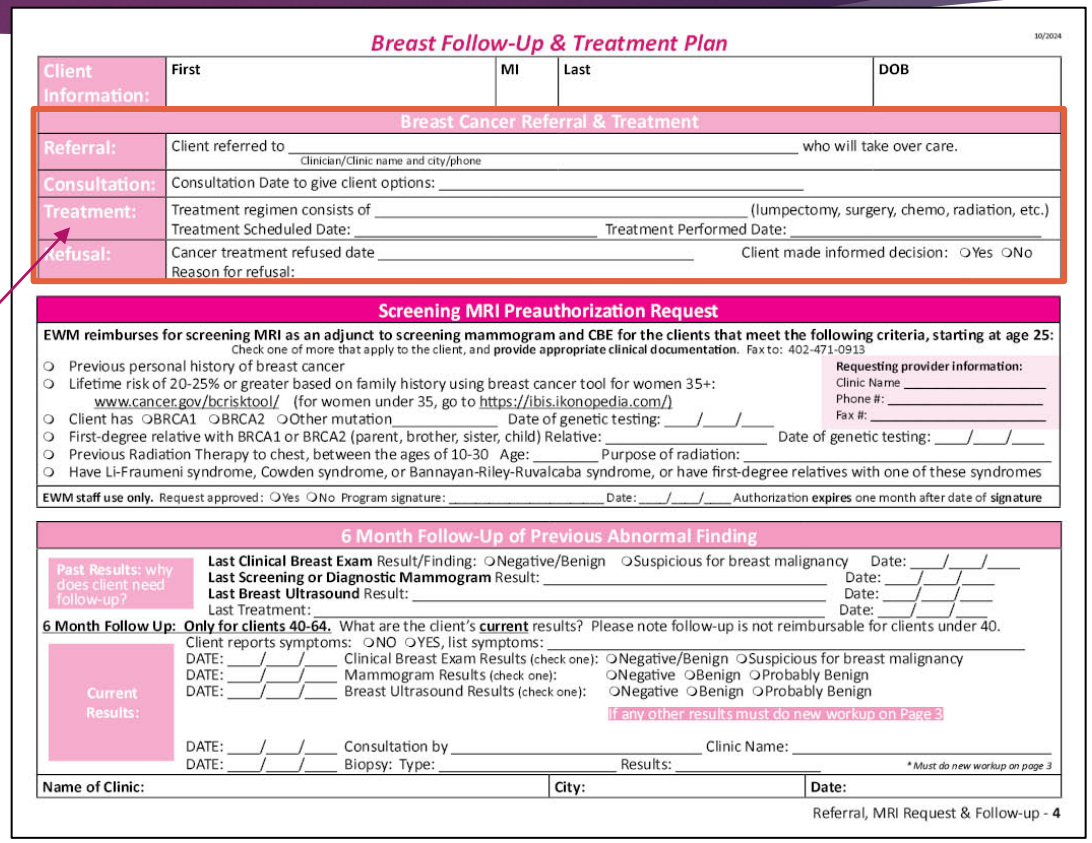
Fax: 402-471-0913 | | Mail: Every Woman Matters, P.O. Box 94817, Lincoln, NE 68509-4817 | | Questions: 800-532-2227
To view instructions or to print out forms: www.dhhs.ne.gov/EWMforms
Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Treatment Plan - 3

Page 4 – Breast cancer referral and treatment

If client is diagnosed with breast cancer:

- Mark it on final diagnosis on pg 3
- Indicate type of treatment and where client is being referred (pg 4)
- Fill out Treatment Funds Request Form



Breast Follow-Up & Treatment Plan 10/2024

Client Information:	First	MI	Last	DOB

Breast Cancer Referral & Treatment

Referral:	Client referred to _____ (Clinician/Clinic name and city/phone) who will take over care.
Consultation:	Consultation Date to give client options: _____
Treatment:	Treatment regimen consists of _____ (lumpectomy, surgery, chemo, radiation, etc.) Treatment Scheduled Date: _____ Treatment Performed Date: _____
Refusal:	Cancer treatment refused date _____ Client made informed decision: ❍Yes ❍No Reason for refusal:

Screening MRI Preauthorization Request

EWM reimburses for screening MRI as an adjunct to screening mammogram and CBE for the clients that meet the following criteria, starting at age 25:
Check one of more that apply to the client, and **provide appropriate clinical documentation.** Fax to: 402-471-0913

- ❍ Previous personal history of breast cancer
- ❍ Lifetime risk of 20-25% or greater based on family history using breast cancer tool for women 35+: www.cancer.gov/bcrisktool/ (for women under 35, go to https://ibis.ikonopedia.com/)
- ❍ Client has ❍BRCA1 ❍BRCA2 ❍Other mutation_____ Date of genetic testing: ____/____/____
- ❍ First-degree relative with BRCA1 or BRCA2 (parent, brother, sister, child) Relative: _____ Date of genetic testing: ____/____/____
- ❍ Previous Radiation Therapy to chest, between the ages of 10-30 Age: _____ Purpose of radiation: _____
- ❍ Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first-degree relatives with one of these syndromes

Requesting provider information:
Clinic Name _____
Phone #: _____
Fax #: _____

EWM staff use only. Request approved: ❍Yes ❍No Program signature: _____ Date: ____/____/____ Authorization **expires** one month after date of **signature**

6 Month Follow-Up of Previous Abnormal Finding

Past Results: why does client need follow-up?

Last Clinical Breast Exam Result/Finding: ❍Negative/Benign ❍Suspicious for breast malignancy Date: ____/____/____
Last Screening or Diagnostic Mammogram Result: _____ Date: ____/____/____
Last Breast Ultrasound Result: _____ Date: ____/____/____
Last Treatment: _____ Date: ____/____/____

6 Month Follow Up: Only for clients 40-64. What are the client's **current** results? Please note follow-up is not reimbursable for clients under 40.

Current Results:

Client reports symptoms: ❍NO ❍YES, list symptoms: _____
DATE: ____/____/____ Clinical Breast Exam Results (check one): ❍Negative/Benign ❍Suspicious for breast malignancy
DATE: ____/____/____ Mammogram Results (check one): ❍Negative ❍Benign ❍Probably Benign
DATE: ____/____/____ Breast Ultrasound Results (check one): ❍Negative ❍Benign ❍Probably Benign
If any other results must do new workup on Page 3
DATE: ____/____/____ Consultation by _____ Clinic Name: _____
DATE: ____/____/____ Biopsy: Type: _____ Results: _____ *Must do new workup on page 3

Name of Clinic:	City:	Date:

Referral, MRI Request & Follow-up - **4**

Women's Cancer Program

- If your client is diagnosed with breast cancer through EWM, by Nebraska state statute she may be eligible for Nebraska Medicaid (for at least 6 months) for cancer treatment through the **Women's Cancer Program (WCP)**
  - this treatment Medicaid is specific to our program including EWM income guidelines (250% of Federal Poverty Guidelines)
  - clients with a breast cancer diagnosis have access to WCP Medicaid throughout their breast cancer treatment
  - **We provide the client with the WCP Medicaid application**
  - clients must **not** have adequate health insurance in order to be eligible for Medicaid through Women's Cancer Program
    - If client has insurance that is limited coverage/benefits, we will work with Medicaid to determine if insurance is considered creditable or not. If insurance is deemed not creditable, client may be eligible for WCP.

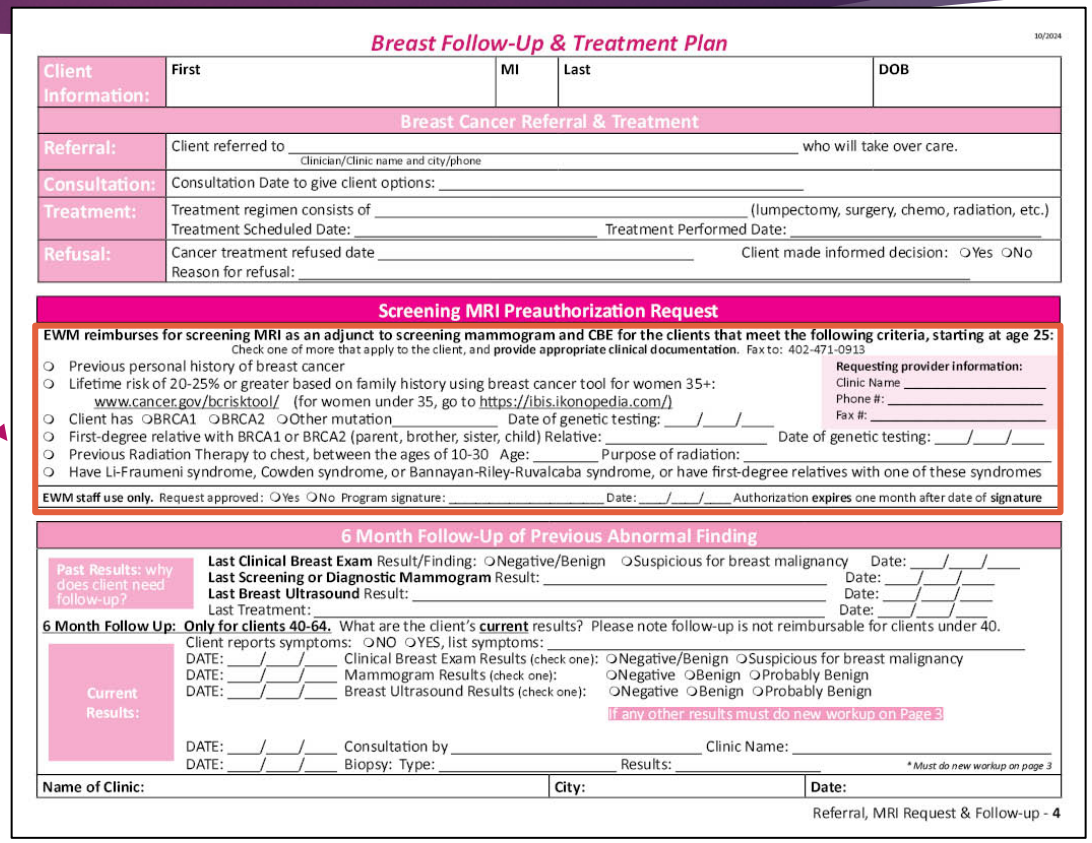
Women's Cancer Program

If client is diagnosed with breast cancer:

- Call EWM at 1-800-532-2227 and ask for the nurse if you have any questions or need to discuss next steps.
- EWM staff will contact client and send out our Medicaid form.
- Although not required, we do appreciate a "heads up" phone call so we can get the process of helping your patient to apply for Medicaid started **as quickly as possible,** as this process takes time.
- Clinic should submit the Treatment Funds Request Form to EWM.

Page 4 – Screening MRI Pre-authorization request

- Screening MRIs must be preauthorized
  - Contact EWM with questions
  - Approval will be given via fax
- EWM covers MRIs for diagnostic purposes on a case-by-case basis
- Screening MRIs are ONLY for women at high risk of breast cancer
  - Guidelines set by CDC (our funder)



Breast Follow-Up & Treatment Plan 10/2024

Client Information:	First	MI	Last	DOB

Breast Cancer Referral & Treatment

Referral:	Client referred to _____ (Clinician/Clinic name and city/phone) who will take over care.
Consultation:	Consultation Date to give client options: _____
Treatment:	Treatment regimen consists of _____ (lumpectomy, surgery, chemo, radiation, etc.) Treatment Scheduled Date: _____ Treatment Performed Date: _____
Refusal:	Cancer treatment refused date _____ Client made informed decision: ❍Yes ❍No Reason for refusal: _____

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Check one of more that apply to the client, and **provide appropriate clinical documentation.** Fax to: 402-471-0913

- ❍ Previous personal history of breast cancer
- ❍ Lifetime risk of 20-25% or greater based on family history using breast cancer tool for women 35+: www.cancer.gov/bcrisktool/ (for women under 35, go to https://ibis.ikonopedia.com/)
- ❍ Client has ❍BRCA1 ❍BRCA2 ❍Other mutation_____ Date of genetic testing: ____/____/____
- ❍ First-degree relative with BRCA1 or BRCA2 (parent, brother, sister, child) Relative: _____ Date of genetic testing: ____/____/____
- ❍ Previous Radiation Therapy to chest, between the ages of 10-30 Age: _____ Purpose of radiation: _____
- ❍ Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first-degree relatives with one of these syndromes

Requesting provider information:
Clinic Name _____
Phone #: _____
Fax #: _____

EWM staff use only. Request approved: ❍Yes ❍No Program signature: _____ Date: ____/____/____ Authorization **expires** one month after date of **signature**

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Past Results: why does client need follow-up?

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Last Breast Ultrasound Result: _____ Date: ____/____/____
Last Treatment: _____ Date: ____/____/____

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Current Results:

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If any other results must do new workup on Page 3
DATE: ____/____/____ Consultation by _____ Clinic Name: _____
DATE: ____/____/____ Biopsy: Type: _____ Results: _____ *Must do new workup on page 3

Name of Clinic:	City:	Date:

Referral, MRI Request & Follow-up - **4**

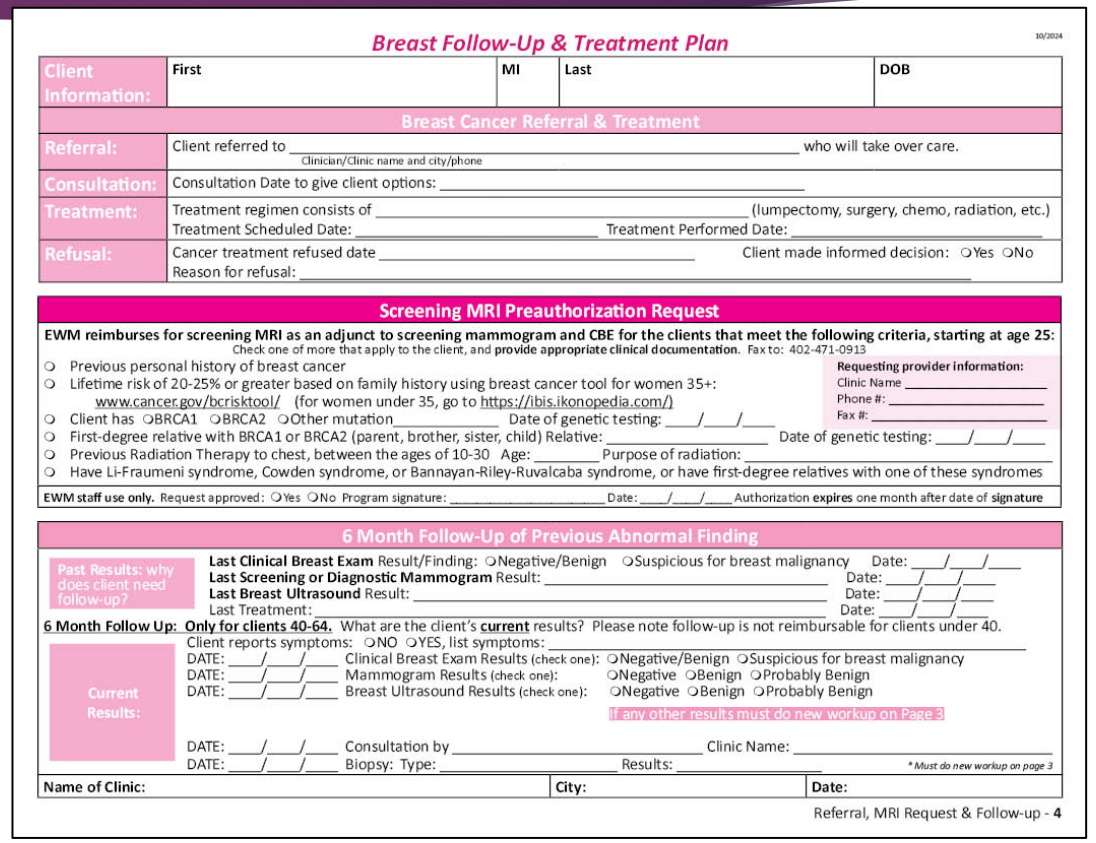
Page 4 – Screening MRI Pre-authorization request eligibility criteria

In order to be eligible, client must have documentation of one of the following risk factors:

- Personal history of breast cancer
- Lifetime risk of developing breast cancer of 20-25% or greater using a breast cancer risk tool
  - Must use credible risk assessment tool:
    - For women 25+ may use https://ibis.ikonopedia.com/
    - For women 35+ may use https://bcrisktool.cancer.gov/
  - Print off results and send in along with request
- Known BRCA1 or BRCA2 mutation, or 1st degree relative with it
- Radiation to the chest between the ages of 10-30
- Li-Fraumeni syndrome, Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome or first degree relative with one of these syndromes

Page 4 – Screening MRI Pre-authorization request

- To request MRI, submit middle section of page 4 along with clinical documentation of the criterion selected
- Pre-Authorization expires 1 month after signature date



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DATE: ____/____/____ Biopsy: Type: _____ Results: _____ *Must do new workup on page 3

Name of Clinic:	City:	Date:

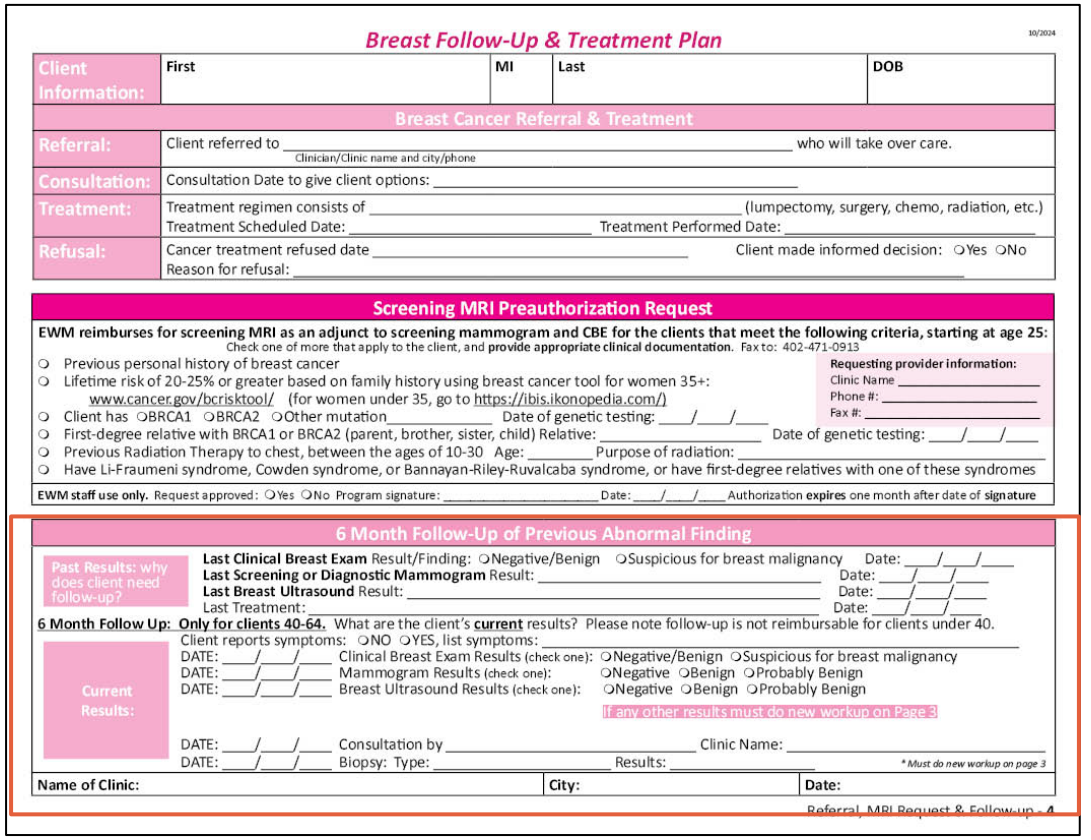
Referral, MRI Request & Follow-up - **4**

Screening MRI - FAQ

- **What if my client needs an MRI and does not have any qualifying criteria, or lifetime risk is less than 20%?**
  - If client does not have any of the conditions listed as criterion, she is not eligible for screening MRI through EWM.
- **What if I have documentation from a physician that an MRI is strongly recommended?**
  - Client still has to meet one of the aforementioned qualifying criteria. Physician recommendation absent of these risk factors does not qualify a client for screening MRI.
  - There are other resources outside EWM that may be able to help.

Page 4 – Follow-up of Previous Abnormal Finding

- Only for women who need follow-up after a previous finding on ultrasound or mammogram, for example:
  - Those who had findings of "probably benign" and need 6-month follow-up
  - Those who had negative biopsies and need follow-up
- **Follow-up is reimbursable ONLY for clients ages 40-64.** Client must be enrolled. Call if you are not sure.
- Pre-authorization not needed, but must follow NCCN guidelines
- CBE expected before the follow-up imaging is performed



Breast Follow-Up & Treatment Plan 10/2024

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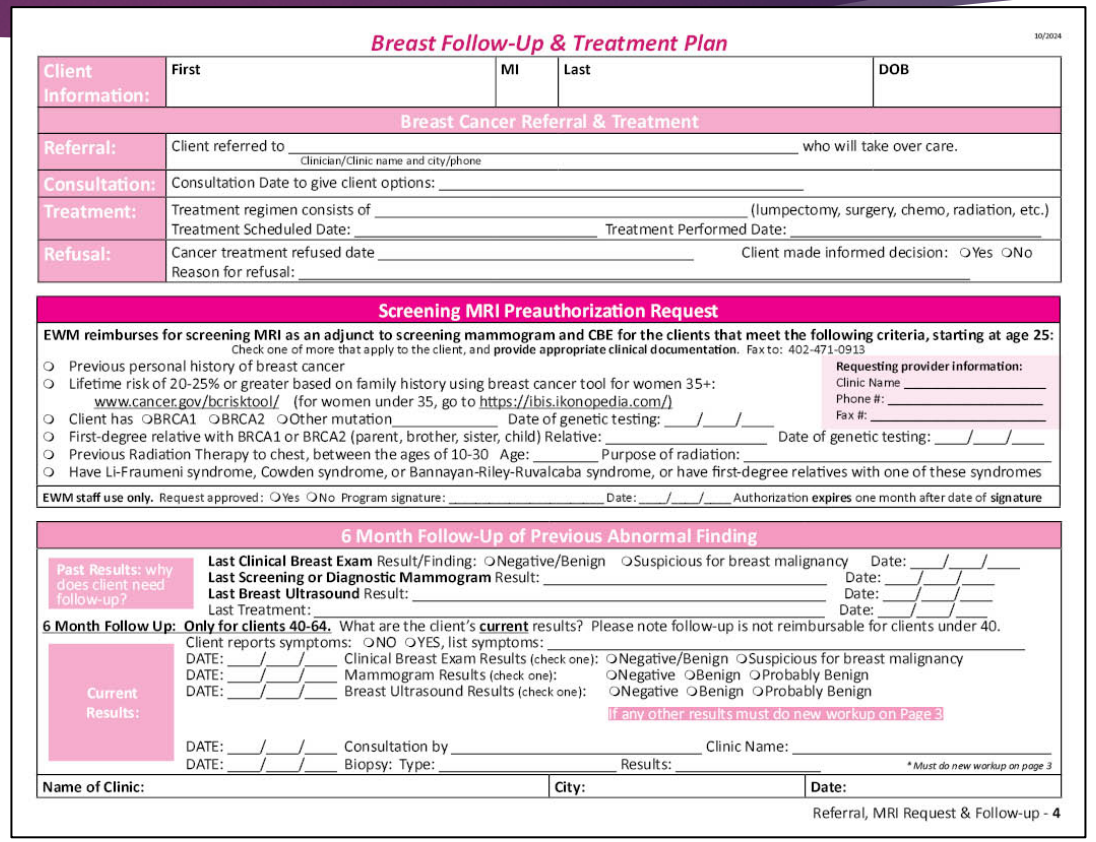
If any other results must do new workup on Page 3
DATE: ____/____/____ Consultation by _____ Clinic Name: _____
DATE: ____/____/____ Biopsy: Type: _____ Results: _____ * *Must do new workup on page 3*

Name of Clinic:	City:	Date:

Referral, MRI Request & Follow-up - 4

Page 4 – Follow-up of Previous Abnormal Finding

- Fill out the previous abnormal finding that your patient needs follow-up from
- Under the 6-month Follow-up, fill out the date and results of your patient's current findings
- You do NOT have to fill out page 3 if it's a 6-month follow-up, only bottom of page 4.
- Send to EWM along with corresponding clinical documentation within 2 weeks of date of service



Breast Follow-Up & Treatment Plan 10/2024

Client Information:	First	MI	Last	DOB

Breast Cancer Referral & Treatment

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❍ Client has ❍BRCA1 ❍BRCA2 ❍Other mutation_____ Date of genetic testing: ____/____/____
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6 Month Follow-Up of Previous Abnormal Finding

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Last Treatment: _____ Date: ____/____/____

6 Month Follow Up: Only for clients 40-64. What are the client's **current** results? Please note follow-up is not reimbursable for clients under 40.

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DATE: ____/____/____ Breast Ultrasound Results (check one): ❍Negative ❍Benign ❍Probably Benign
If any other results must do new workup on Page 3
DATE: ____/____/____ Consultation by _____ Clinic Name: _____
DATE: ____/____/____ Biopsy: Type: _____ Results: _____ *Must do new workup on page 3

Name of Clinic:	City:	Date:

Referral, MRI Request & Follow-up - **4**

Hereditary Breast Cancer Screening Protocol (BRCA mutations)

Only on clients with documented personal history of BRCA1 or BRCA2 gene mutations. EWM will need to see clinical documentation of this.

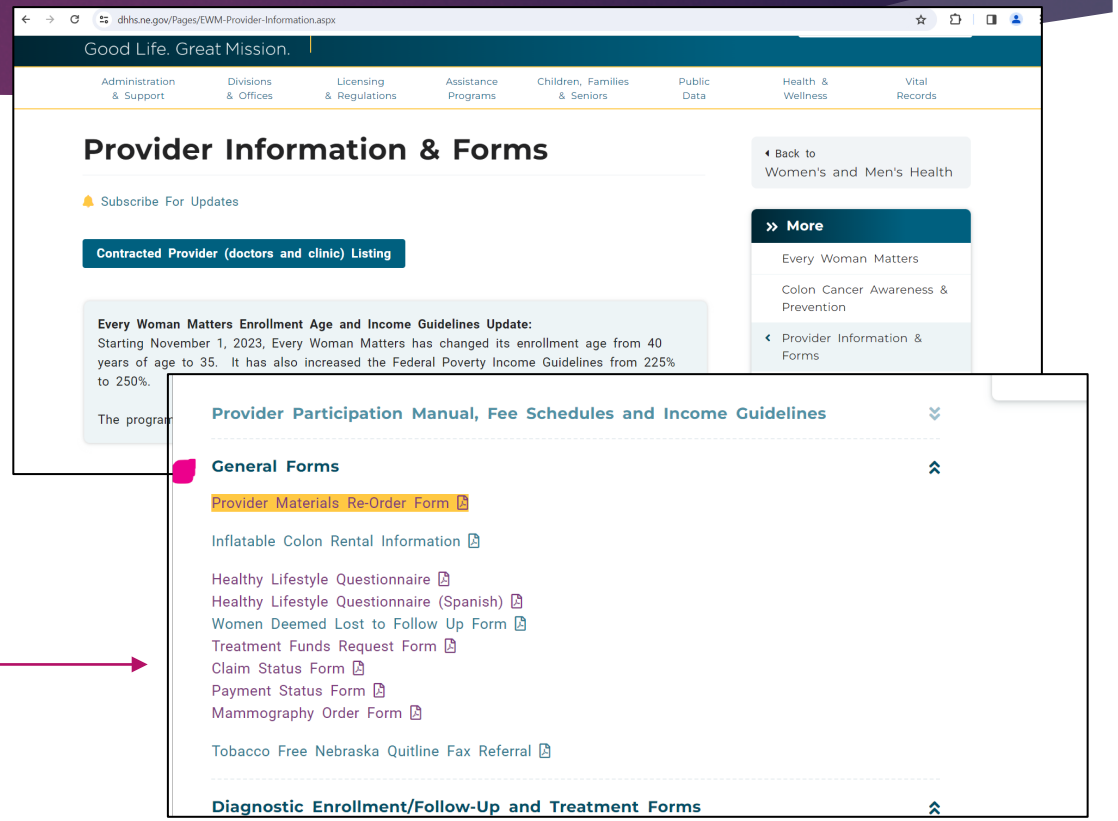
- **Clients age 25-39:** eligible for annual breast MRI screening (a screening mammogram is not reimbursed by EWM).
  - Initiation of screening would be individualized based on earliest age of onset in family.
- **Clients age 40 through 64:**
  - annual screening mammogram at the time of her EWM screening visit or immediately afterward,
  - breast MRI screening alternating 6 months after the screening mammogram.

Other forms you will need

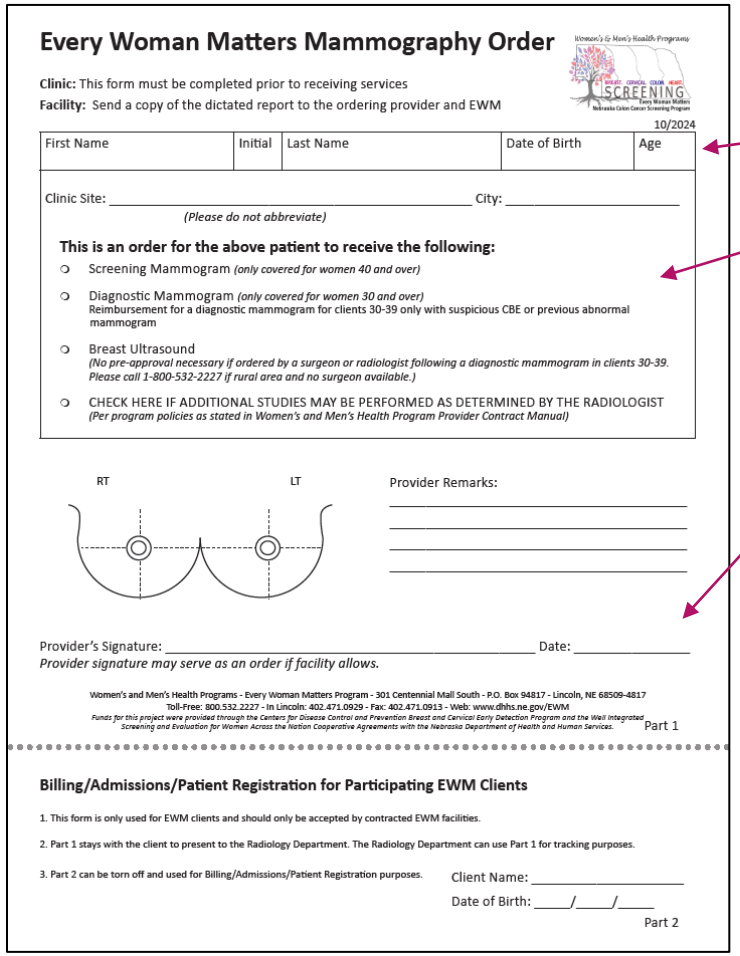
MAMMOGRAPHY ORDER FORM

Mammography Order Form

- If you are ordering any imaging on a client, you MUST send her with a Mammography Order Form
- Client presents this form to radiology so they know to bill EWM for services
- These forms are found online at www.dhhs.ne.gov/ewmforms
- If you do not do this, the client will get charged for services



Mammography Order Form



Every Woman Matters Mammography Order

Clinic: This form must be completed prior to receiving services
Facility: Send a copy of the dictated report to the ordering provider and EWM

10/2024

First Name	Initial	Last Name	Date of Birth	Age

Clinic Site: _____ City: _____
(Please do not abbreviate)

This is an order for the above patient to receive the following:

- ❍ Screening Mammogram *(only covered for women 40 and over)*
- ❍ Diagnostic Mammogram *(only covered for women 30 and over)*
  Reimbursement for a diagnostic mammogram for clients 30-39 only with suspicious CBE or previous abnormal mammogram
- ❍ Breast Ultrasound
  (No pre-approval necessary if ordered by a surgeon or radiologist following a diagnostic mammogram in clients 30-39. Please call 1-800-532-2227 if rural area and no surgeon available.)
- ❍ CHECK HERE IF ADDITIONAL STUDIES MAY BE PERFORMED AS DETERMINED BY THE RADIOLOGIST
  (Per program policies as stated in Women's and Men's Health Program Provider Contract Manual)

RT LT

Provider Remarks: _____

Provider's Signature: _____ Date: _____
Provider signature may serve as an order if facility allows.

Women's and Men's Health Programs - Every Woman Matters Program - 301 Centennial Mall South - P.O. Box 94817 - Lincoln, NE 68509-4817
Toll-Free: 800.532.2227 - In Lincoln: 402.471.0929 - Fax: 402.471.0913 - Web: www.dhhs.ne.gov/EWM
Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Part 1

Billing/Admissions/Patient Registration for Participating EWM Clients

1. This form is only used for EWM clients and should only be accepted by contracted EWM facilities.
2. Part 1 stays with the client to present to the Radiology Department. The Radiology Department can use Part 1 for tracking purposes.
3. Part 2 can be torn off and used for Billing/Admissions/Patient Registration purposes.

Client Name: _____
Date of Birth: ____/____/____

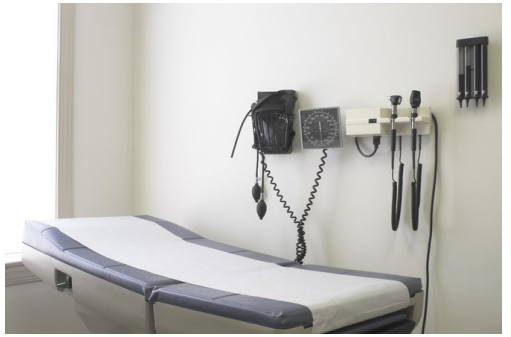
Part 2

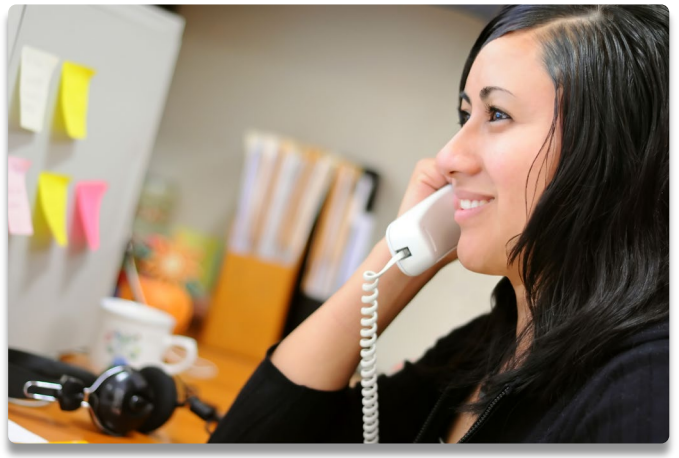
- Fill out client's information
- Select what imaging to order
- Provider signs and dates

Send this form with the client to take with her to get the mammogram or ultrasound done!

Let's talk about processes

What does enrolling a client into the Every Woman Matters Breast Diagnostic Program look like in real life?

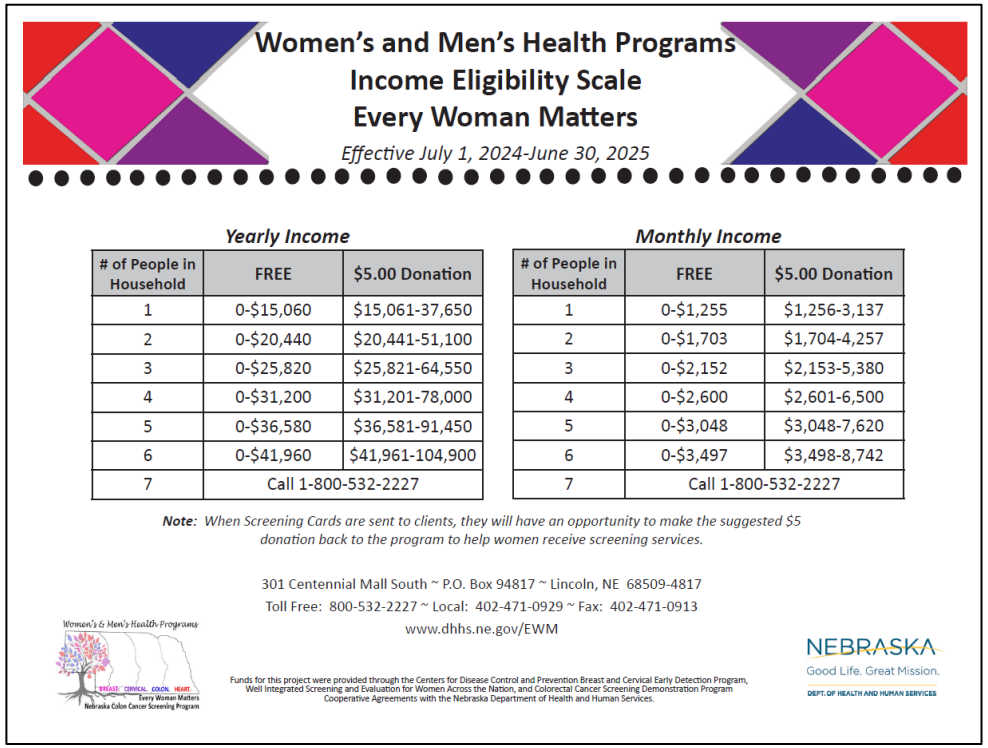




Let's Recap – real life scenario

What do you need to verify?

- **Age**: needs to be 18-64
- **Income**: see chart
- **Citizenship**: needs to be a US citizen or Permanent Resident (and we need to have copy of front and back of Permanent Resident card to verify)
- **Health**: needs services to diagnose breast problem (and she already told you she has a breast lump)
- Insurance: does not matter if she has insurance or not, can enroll either way



Women's and Men's Health Programs
Income Eligibility Scale
Every Woman Matters
Effective July 1, 2024-June 30, 2025

Yearly Income

# of People in Household	FREE	$5.00 Donation
1	0-$15,060	$15,061-37,650
2	0-$20,440	$20,441-51,100
3	0-$25,820	$25,821-64,550
4	0-$31,200	$31,201-78,000
5	0-$36,580	$36,581-91,450
6	0-$41,960	$41,961-104,900
7	Call 1-800-532-2227	

Monthly Income

# of People in Household	FREE	$5.00 Donation
1	0-$1,255	$1,256-3,137
2	0-$1,703	$1,704-4,257
3	0-$2,152	$2,153-5,380
4	0-$2,600	$2,601-6,500
5	0-$3,048	$3,048-7,620
6	0-$3,497	$3,498-8,742
7	Call 1-800-532-2227	

Note: *When Screening Cards are sent to clients, they will have an opportunity to make the suggested $5 donation back to the program to help women receive screening services.*

301 Centennial Mall South ~ P.O. Box 94817 ~ Lincoln, NE 68509-4817
Toll Free: 800-532-2227 ~ Local: 402-471-0929 ~ Fax: 402-471-0913
www.dhhs.ne.gov/EWM

Women's & Men's Health Programs
BREAST CERVICAL COLON HEART
Every Woman Matters
Nebraska Colon Cancer Screening Program

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services.

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

How to help – starting from the beginning

Can I ask you your age and income level? And are you a US citizen or permanent resident?

Yes, I am 21 and make $1200 a month. I am a US citizen.

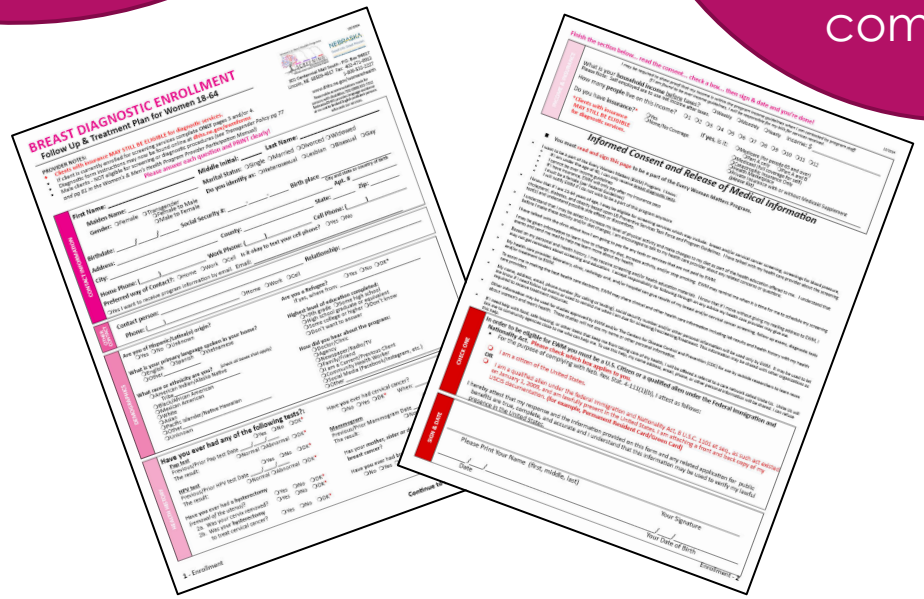
How to help – starting from the beginning

Great! Looks like you are eligible for Every Woman Matters. We can enroll you once you get here. Let's set up an appointment right away.

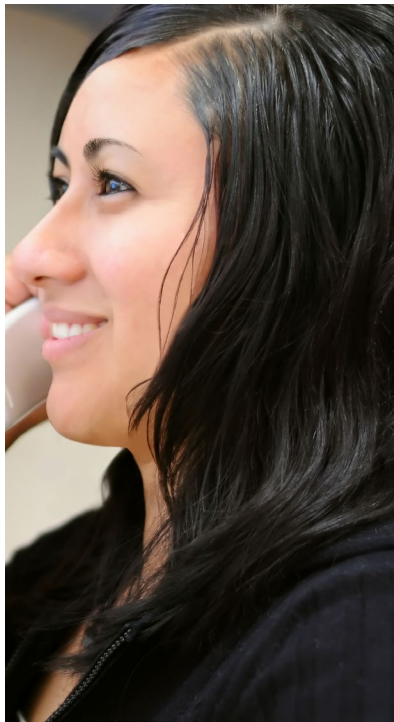
Great! Thanks!

Later, at the office

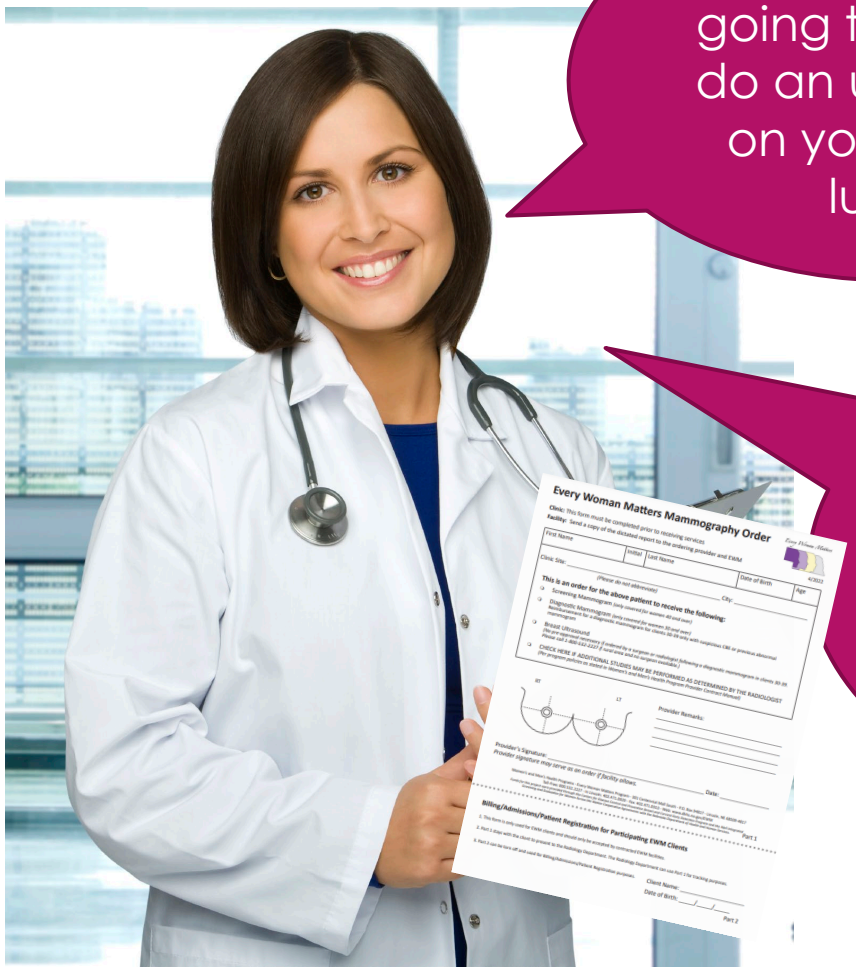
Hi, I am here for my Every Woman Matters appointment.



OK. Just fill out pages 1 and 2 of the Breast Diagnostic Enrollment form and the doctor will see you soon. Make sure all sections are completed.



During the appointment



Hi there. We're going to need to do an ultrasound on your breast lump.

Yes, just make sure you bring this Mammography Order form with you to your appointment.

That sounds expensive. Will Every Woman Matters cover it?

Great!

After the appointment

What do I do with her Breast Diagnostic Enrollment Form? Do I need to send it to Every Woman Matters right now?

No, you wait until we get the results back of the ultrasound or *until we have reached a final diagnosis.*

Then you send in the Breast form *along with* radiology reports.

I knew what services she was eligible for based on the chart on page 3 and the instructions I printed off from the website.

I knew she was eligible for the program because I verified her age, income, and citizenship and knew she needed to diagnose a breast problem.

And I was able to get care for my breast problem without having major medical bills!

And that is how it's done!

Reminders

- Forms and instructions can be found online at www.dhhs.ne.gov/ewmforms . We update forms frequently. Please go to the website for the latest versions
- Follow-up is not covered for women under 40
- Diagnostic mammograms not covered for women under 30
- Screening MRI must be pre-authorized and must meet criteria regardless of physician's recommendations
- Forms must be complete including final diagnosis and providers must submit copies of all diagnostic tests
- Call EWM at 1-800-532-2227 if you have questions!

Additional Questions regarding Breast Diagnostic Enrollment?

Contact an Every Woman Matters representative:

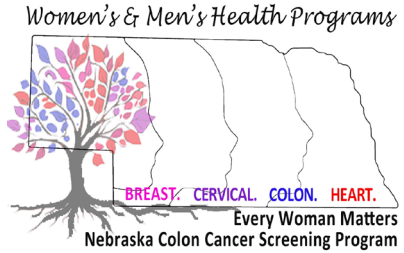
Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/womenshealth web

dhhs.ewm@nebraska.gov email



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