COLON CANCER

Enrollment and Screening

NEBRASKA COLON CANCER SCREENING PROGRAM

Where to Begin

- A Healthy Lifestyle Questionnaire *(HLQ)* is required to be filled out yearly for each client.
- The HLQ should be returned to the Women's and Men's Health Program for approval ***PRIOR*** to service.
- Incomplete forms will be returned and possibly delay screening.

Healthy Lifestyle Questionnaire

Please fill out this form. Filling out this form will help Every Woman Matters (EWM) and the Nebraska Colon Cancer Screening Program (NCP) determine what services are best for you.

Even if you are not able to get services, you can still get health education.

WHAT YOU NEED TO KNOW:

- You must NOT have health insurance that would pay for preventive services.
- Please answer ALL questions. If you don't we will call you or send the form back to you and this could delay important health screenings.
- Please PRINT clearly. Use a black or blue ink pen. Do not use pencil.
- This is NOT your screening card. Please do not make an appointment with your health care provider until you get a Screening Card.
- After you send this to EWM/NCP, it will be reviewed to see what screenings you are eligible for. This usually takes up to 2 weeks.

WHAT YOUR PROVIDER NEEDS TO KNOW:

- Screenings were determined based upon the HLQ submitted to EWM/NCP.
- This HLQ was mailed back to the client with a Screening Card. Client was instructed to bring the form so you can discuss benefits of healthy lifestyle behaviors.
- Clinics may keep the HLQ as a part of the client chart, if so desired.

Thank you for taking time for your health!

Version: 10/2024

Obtaining Healthy Lifestyle Questionnaires

- Online enrollment (English and Spanish) are available at dhhs.ne.gov/ewm by clicking the "Enroll Now" button.
- Clients may request a HLQ via mail by calling1-800-532-2227 and leaving a message on the enrollment line. HLQs are mailed daily.
- HLQ's can be downloaded by going to dhhs.ne.gov/ewmforms

*** clients are not eligible for screening until they receive notification from the program**

How Eligibility for Services is Determined

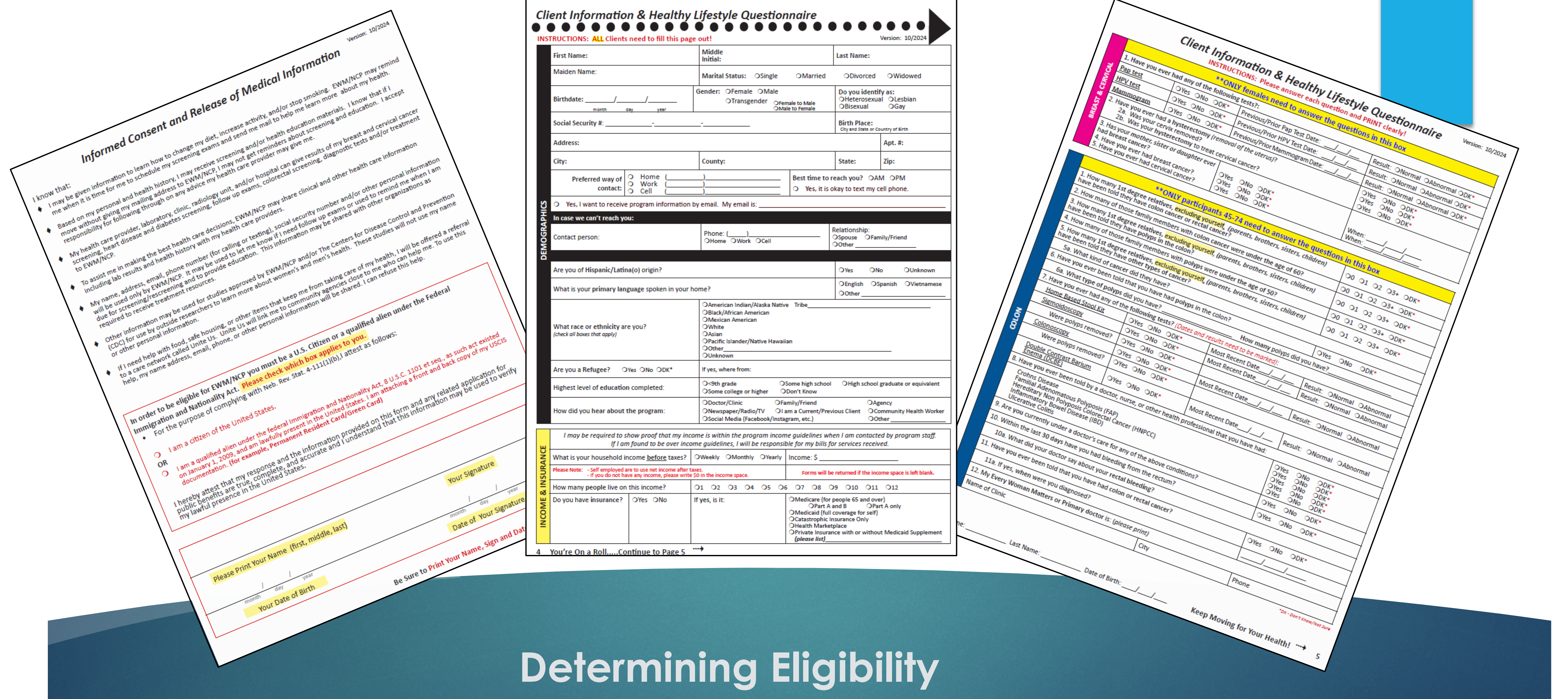
Eligibility criteria to receive services allowed through NCP is based on:

- ✓ Age
- ✓ Personal and Family Health History
- ✓ Client Self-Reported Screening History
- ✓ Previous screening history documented through NCP
- ✓ Recommendations made by the EWM/NCP Medical Advisory Committee

In the event that the client incorrectly self-reported or the provider believes that they are at increased risk and should be screened for a service deemed ineligible, please contact NCP at 1-800-532-2227

Program Eligibility

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



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Informed Consent and Release of Medical Information

I know that:

- I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM/NCP 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/NCP, 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 cervical cancer screening, heart disease and diabetes screening, follow up exams, colorectal screening, diagnostic tests and/or treatment to EWM/NCP.
- To assist me in making the best health care decisions, EWM/NCP 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/NCP. 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 and to provide education. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM/NCP 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.

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. 4-111(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.

Your Signature

month / day / year — Date of Your Signature

Please Print Your Name (first, middle, last)

month / day / year — Your Date of Birth

Be Sure to Print Your Name, Sign and Date

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: ALL Clients need to fill this page out! — Version: 10/2024

DEMOGRAPHICS

First Name: | Middle Initial: | Last Name:

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

Birthdate: ___/___/___ (month day year) | Gender: ○Female ○Male ○Transgender ○Female to Male ○Male to Female | Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay

Social Security #: ___-___-___ | Birth Place: (City and State or Country of Birth)

Address: | Apt. #:

City: | County: | State: | Zip:

Preferred way of contact: ○ Home ○ Work ○ Cell | Best time to reach you? ○AM ○PM | ○ Yes, it is okay to text my cell phone.

○ Yes, I want to receive program information by email. My email is: ______

In case we can't reach you:

Contact person: | Phone: ( ) ○Home ○Work ○Cell | Relationship: ○Spouse ○Family/Friend ○Other

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

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

What race or ethnicity are you? (check all boxes that apply) ○American Indian/Alaska Native Tribe___ ○Black/African American ○Mexican American ○White ○Asian ○Pacific Islander/Native Hawaiian ○Other___ ○Unknown

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

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

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

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. - If you do not have any income, please write $0 in the income space. | Forms will be returned if the income space is left blank.

How many people live on this income? ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ○11 ○12

Do you have insurance? ○Yes ○No | If yes, is it: ○Medicare (for people 65 and over) ○Part A and B ○Part A only ○Medicaid (full coverage for self) ○Catastrophic Insurance Only ○Health Marketplace ○Private Insurance with or without Medicaid Supplement (please list)

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Client Information & Healthy Lifestyle Questionnaire — Version: 10/2024

INSTRUCTIONS: Please answer each question and PRINT clearly!

BREAST & CERVICAL — **ONLY females need to answer the questions in this box

1. Have you ever had any of the following tests? Pap test ○Yes ○No ○DK* Previous/Prior Pap Test Date: Result: ○Normal ○Abnormal ○DK*; HPV test ○Yes ○No ○DK* Previous/Prior HPV Test Date: Result: ○Normal ○Abnormal ○DK*; Mammogram ○Yes ○No ○DK* Previous/Prior Mammogram Date: Result: ○Normal ○Abnormal ○DK*
2. Have you ever had a hysterectomy (removal of the uterus)? 2a. Was your cervix removed? 2b. Was your hysterectomy to treat cervical cancer?
3. Has your mother, sister or daughter ever had breast cancer?
4. Have you ever had breast cancer? When:
5. Have you ever had cervical cancer? When:

COLON — **ONLY participants 45-74 need to answer the questions in this box

1. How many 1st degree relatives, excluding yourself, (parents, brothers, sisters, children) have been told they have colon cancer or rectal cancer? ○0 ○1 ○2 ○3+ ○DK*
2. How many of those family members with colon cancer were under the age of 60?
3. How many 1st degree relatives, excluding yourself, (parents, brothers, sisters, children) have been told they have polyps in the colon?
4. How many of those family members with polyps were under the age of 50?
5. How many 1st degree relatives, excluding yourself, (parents, brothers, sisters, children) have been told they have other types of cancer? 5a. What kind of cancer did they have?
6. Have you ever been told that you have had polyps in the colon? 6a. What type of polyps did you have? How many polyps did you have?
7. Have you ever had any of the following tests? (Dates and results need to be marked): Home Based Stool Kit — Most Recent Date — Result: ○Normal ○Abnormal; Sigmoidoscopy — Were polyps removed? — Most Recent Date — Result: ○Normal ○Abnormal; Colonoscopy — Were polyps removed? — Most Recent Date — Result: ○Normal ○Abnormal; Double Contrast Barium Enema (DCBE) — Most Recent Date — Result: ○Normal ○Abnormal
8. Have you ever been told by a doctor, nurse, or other health professional that you have had: Crohns Disease; Familial Adenomatous Polyposis (FAP); Hereditary Non Polyposis Colorectal Cancer (HNPCC); Inflammatory Bowel Disease (IBD); Ulcerative Colitis
9. Are you currently under a doctor's care for any of the above conditions?
10. Within the last 30 days have you had bleeding from the rectum? 10a. What did your doctor say about your rectal bleeding?
11. Have you ever been told that you have had colon or rectal cancer? 11a. If yes, when were you diagnosed?
12. My Every Woman Matters or Primary doctor is: (please print) — Name of Clinic — City — Phone

Last Name — Date of Birth

*DK - Don't Know/Not Sure

Keep Moving for Your Health! 5

Determining Eligibility

Information gathered from the client's HLQ will be used to determine whether or not they will be eligible for services and when it is appropriate for them to be screened.

Who is Eligible

Uninsured Clients
ages 45-74

United States
Residents

Income Eligible

Who is Eligible – Uninsured Clients

Uninsured Clients ages 45-74

In order to be eligible, screening clients must not have other health coverage that will pay for preventive services.

- Clients with Private Health Insurance, Medicare Part B or Medicaid are **not eligible** for screening services if their coverage includes preventive services.
- If their plan does not cover preventive services, please contact EWM/NCP at 800-532-2227 to determine enrollment eligibility.

Who is Eligible – United States Residents

United States Residents

Must be a citizen or permanent resident of the United States.

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.
  - Their status will be checked in the Federal SAVE System before program approval.
  - Passports, Work VISA's, etc. ***are not*** sufficient proof of residency for this program.

Who is Eligible – Income Guidelines

Income Guidelines

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

Current income guidelines

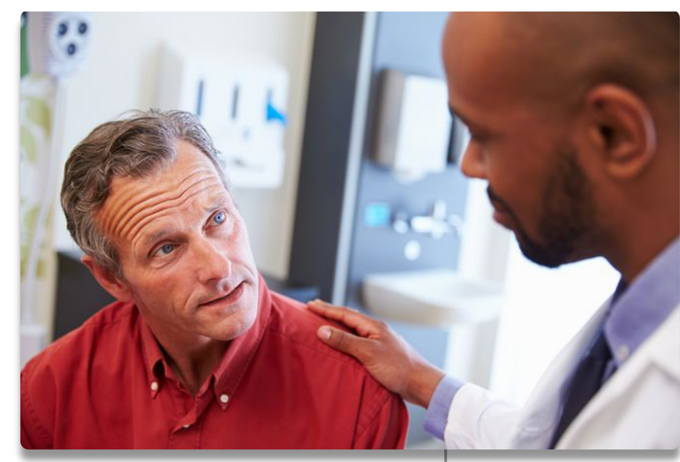
Household income is self-reported. No verification or documentation of income is required. Enrolling clients report their gross annual income before deductions. All persons living in the same house and being supported by the income are to be included in the number of people in the household. All income coming into the home that supports the household is to be counted.

- Those with farm incomes or non-farm self-employment are asked to record the amount of net income after business deductions.
- If the client has no income, it is still required to report as "0" to avoid a delay in processing.

Other Factors that Determine Eligibility

The HLQ will be reviewed by NCP Staff to determine most effective screening test, according to the guidelines developed by the EWM/NCP Medical Advisory Council.

Factors taken into consideration include:



Personal History

Family History

Determining Eligibility – Personal History

Personal History

The following screening tests may be determined based on the client's personal history

Education and Referral to the Primary Healthcare Provider

- Clients **under** the age of 45 that complete and submit the Healthy Lifestyle Questionnaire
- Clients age 45-74
  - Symptomatic with rectal bleeding
  - Previous diagnosis of Crohn's disease, Ulcerative Colitis, Inflammatory Bowel Disease (IBD), Familial Adenomatous Polyposis (FAP), and/or Hereditary Non Polyposis Colorectal Cancer (HNPCC)

At Home Screening Test (FIT Kit)

- Clients age 45-74 who have not been screened with:
  - Colonoscopy in last 10 years.
  - Fecal Occult Blood Test (FOBT) in last 12 months.
  - Sigmoidoscopy in last 5 years.
  - Double Contrast Barium Enema (DCBE) within the last 5 years.
- Clients must be asymptomatic

Colonoscopy

- Clients over the age of 45 previously diagnosed with Colon or rectal cancer

Determining Eligibility – Family History

Family History

The following screening tests may be determined based on the client's family history

Education and Referral to the Primary Healthcare Provider

- Clients age 45-74
  - 2 or more 1st degree relatives diagnosed with colon cancer under the age of 60 will be referred for hereditary evaluation for colon cancer.
  - Hereditary Non Polyposis Colorectal Cancer (HNPCC) or Familial Adenomatous Polyposis (FAP)

At Home Screening Test (FIT Kit)

- Clients age 45-74 with 0 or 1 1st degree relative diagnosed over the age of 60 with colon cancer or colon polyps

Colonoscopy

- Clients age 45-74 with
  - 1 1st degree relative diagnosed with colon cancer under the age of 60
  - 2 or more 1st degree relatives over the age of 60 diagnosed with colon cancer
  - 1 or more 1st degree relatives diagnosed under the age of 50 with colon polyps
  - 2 or more 1st degree relatives over age 50 with colon polyps

Frequently Asked Questions

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

NCP FAQ

- **What if a client under the age of 45 needs a home based screening test or colonoscopy?**
  If the client is under the age of 45, they are not eligible to enroll or to receive services under the Nebraska Colon Cancer Screening Program (NCP).
- **Are there instructions on how to do the FIT Kit?**
  Yes, there are instructions included with each FIT Kit. There are also instructions featured on our website in English and in Spanish on how to do the FIT Kit.
- **I have a client who needs a FIT Kit. How do I go about getting one for them?**
  On the website there is a FIT Kit Request Form that anyone 45 and older can fill out in order to request a Fit Kit. Once a request is received a kit will either be mailed out from the central office or the request will be sent to the region in which the client is from if there is an active health department so that the health department can take an active role in that community members health.
- **Does NCP help men or women who live in another state?**
  Individuals who are not a Nebraska resident (even though they may have a primary care provider in Nebraska) are not eligible to enroll in the Nebraska Colon Cancer Screening Program.

Additional questions?

Contact an Nebraska Colon Cancer Screening Program representative:

Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/crc web

dhhs.nccsp@nebraska.gov email