Nebraska Colon Cancer Screening Program

Screening Colonoscopy Post Positive Non-Invasive Stool Test Enrollment

Fill out this Nebraska Colon Cancer Screening Program (NCP) Screening Colonoscopy Post Positive Non-Invasive Stool Test Enrollment if you:

- Are 45-74 years of age
- Are a citizen or legal resident of Nebraska
- Meet program income guidelines
- Don't have health insurance that would pay for preventive health services
- Have had a positive home based stool test such as FOBT, FIT or Cologuard.

# of People in Household	YEARLY Income
1	0-$37,650
2	0-$51,100
3	0-$64,550
4	0-$78,000
5	0-$91,450
6	0-$104,900
7	Call 1-800-532-2227

Filling out this form will help NCP determine what screening test is best for you.

Tests and services may include a FIT test for at-home testing and/or colonoscopy. All screenings are based upon family and personal history and must be pre-approved by NCP staff. 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.
- If you are eligible for a colonoscopy NCP will work directly with you to set that up.

If you have questions, please contact:

Nebraska Women's & Men's Health Programs
Every Woman Matters || Nebraska Colon Cancer Screening 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
Websites: www.dhhs.ne.gov/womenshealth || www.dhhs.ne.gov/crc
Email: dhhs.ewm@nebraska.gov || dhhs.nccsp@nebraska.gov

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

Version: 5/2025

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.

Informed Consent and Release of Medical Information

Version: 5/2025

- **You must read page 2**
- **You are NOT able to enroll until all pages are filled out.**

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- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I know:
  - I must be between 45-74 years of age to receive services (there are no exceptions)
  - I cannot be over income guidelines
  - If I have insurance, NCP will only pay after my insurance pays
  - I must re-enroll in NCP every year
  - I must have a primary care doctor listed
  - I will notify NCP if I do not wish to be a part of this program anymore
  - I must be a Nebraska resident

- If I am eligible to participate, I understand that NCP will look at my health history and tell me what colon cancer screening test I am eligible for.

- Based upon my health history and what type of test I am eligible for, I know that NCP may provide me with a home based stool kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive a home based stool kit from the program and have a positive test, it will be followed up with a colonoscopy.
  - If I receive a colonoscopy through NCP I understand that I may be asked to pay 10% of the cost.
  - I understand that my payments will help others with colonoscopy costs through NCP.

- I will talk with my health care provider about the screening test(s) for colon cancer and understand possible side effects or discomforts.

- I will talk with my health care provider about how I am going to pay for any services that are not paid by NCP.

- I understand that NCP does not pay for treatment if I am diagnosed with colon cancer. NCP staff will assist me in finding treatment resources.

I know that:

- 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 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, and/or hospital can give results of my colorectal screening to NCP.

- To assist me in making the best health care decisions, 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 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 NCP and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about 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.

Please Print Your Name (first, middle, last)

Your Signature

month / day / year
Your Date of Birth

month / day / year
Date of Your Signature

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: ALL Clients need to fill this page out!

Version: 5/2025

DEMOGRAPHICS

First Name:	**Middle Initial:**	**Last Name:**	
Maiden Name:	**Marital Status:** ❍Single ❍Married ❍Divorced ❍Widowed		
Birthdate: _____/_____/_____ month day year	**Gender:** ❍Female ❍Male		
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)***_____

You're On a Roll.....Continue to Page 4 ⇢

Client Information & Healthy Lifestyle Questionnaire

Version: 5/2025

INSTRUCTIONS: Please answer each question and PRINT clearly!

COLON

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**?			❍0 ❍1 ❍2 ❍3+ ❍DK*
3. How many **1st degree relatives,** excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have **polyps in the colon**?			❍0 ❍1 ❍2 ❍3+ ❍DK*
4. How many of those family members with **polyps** were **under the age of 50**?			❍0 ❍1 ❍2 ❍3+ ❍DK*
5. How many **1st degree relatives**, excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have **other types of cancer**?			❍0 ❍1 ❍2 ❍3+ ❍DK*
5a. What kind of **cancer** did they have?			
6. Have **you** ever been told that you have had **polyps** in the colon?			❍Yes ❍No ❍DK*
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	❍Yes ❍No ❍DK*	Most Recent Date___/___/___	Result: ❍Normal ❍Abnormal
Sigmoidoscopy	❍Yes ❍No ❍DK*	Most Recent Date___/___/___	Result: ❍Normal ❍Abnormal
Were polyps removed?	❍Yes ❍No ❍DK*		
Colonoscopy	❍Yes ❍No ❍DK*	Most Recent Date___/___/___	Result: ❍Normal ❍Abnormal
Were polyps removed?	❍Yes ❍No ❍DK*		
Double Contrast Barium Enema (DCBE)	❍Yes ❍No ❍DK*	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			❍Yes ❍No ❍DK* ❍Yes ❍No ❍DK* ❍Yes ❍No ❍DK* ❍Yes ❍No ❍DK* ❍Yes ❍No ❍DK*
9. Are **you** currently under a doctor's care for any of the above conditions?			❍Yes ❍No ❍DK*
10. Within the last **30 days** have you had bleeding from the rectum?			❍Yes ❍No ❍DK*
10a. What did your doctor say about your **rectal bleeding**?			
11. Have **you** ever been told that you have had **colon or rectal cancer**?			❍Yes ❍No ❍DK*
11a. If yes, **when** were you diagnosed?			_____/_____/_____
12. My **Every Woman Matters or Primary doctor** is: (*please print)*			
Name of Clinic		City	Phone

SMOKING

1. Do you **smoke**? Includes cigarettes, pipes, or cigars *(smoked tobacco in any form)*	❍Current Smoker ❍Quit (1-12 months ago) ❍Quit (More than 12 months) ❍Never Smoked

DAILY LIFE

1. Thinking about your **physical health**, which includes physical illness and injury, on how many days during the past **30 days** was your physical health **not good**?	_____ Days ❍DK*
2. Thinking about your **mental health**, which includes stress, depression, and problems with emotions, on how many days during the past **30 days** was your mental health **not good**?	_____ Days ❍DK*
3. During the past **30 days**, on about how many days did poor physical or mental health keep you from doing your **usual activities**, such as self-care, work, or recreation?	_____ Days ❍DK*
4. Are you limited in any activities because of physical, mental or emotional problems?	❍Yes ❍No ❍DK*
5. Do **you now have** any health problems that requires you to use **special equipment**, such as a cane, a wheelchair, a special bed or a special telephone?	❍Yes ❍No ❍DK*
5a. If yes, what **type of disability**?	❍Emotional ❍Intellectual ❍Physical ❍Sensory
6. Over the past 2 weeks, **how often** have you been bothered by any of the following problems: 6a. **Little interest or pleasure in doing things**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day
6b. **Feeling down, depressed, or hopeless**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day

**DK - Don't Know/Not Sure*

Client Information & Healthy Lifestyle Questionnaire

Version: 5/2025

INSTRUCTIONS: Please answer each question and PRINT clearly!

SAFETY & WELLNESS		
	1. How many days in the last week have you had a **drink containing alcohol**?	❍Never _____Days ❍DK*
	1a. On days that you had a drink containing alcohol, **how many drinks** did you have? *(one drink contains 14 grams of pure alcohol, which is found in: 12 ounces of regular beer, 5 ounces of wine or 1.5 ounces of distilled spirits)*	❍Never _____Drinks ❍DK*
	2. **Men:** How many days in the past year have you had 5 or more alcoholic drinks in a day? **Women:** How many days in the past year have you had 4 or more alcoholic drinks in a day?	❍Never _____ Days ❍NA* ❍DK*
	3. During the past 12 months, have you had a **flu shot or flu mist**?	❍No ❍Yes ❍DK*
	3a. If not, please share why?	
	4. Have you had a **pneumonia shot**?	❍No ❍Yes ❍DK*
	5. When did you last visit a **dentist or a dental clinic** for any reason?	❍Within past year ❍Within past 2 years ❍2 or more years ago ❍Never ❍DK*

**DK - Don't Know/Not Sure*

Nebraska Colon Cancer Screening Program CANNOT accept this form without the results.
Please provide FIT Results from the Lab.

Section 1:

Positive Test Date: _____/_____/_____

Paid by:
- ❑ Exact Sciences - Cologuard
- ❑ Beat Cancer - FIT
- ❑ Nebraska Colon Cancer Screening Program - FIT

Primary Care Provider Name:_____
Clinic Name:_____
Clinic Address: _____
Clinic Phone: _____
Clinic Fax: _____

Distributed or Provided by:
- ❑ Central District Health Department - CDHD
- ❑ Elkhorn Logan Valley Public Health Department - ELVPHD
- ❑ Loup Basin Public Health Department - Loup Basin
- ❑ Panhandle Public Health Deaprtment - PPHD
- ❑ Southwest Nebraska Public Health Department - SWNPHD
- ❑ Clinic Name _____
- ❑ East Central District Health Department - ECDHD
- ❑ Lincoln Lancaster County Health Department - LLCHD
- ❑ Northeast Nebraska Public Health Department - NNPHD
- ❑ South Heartland District Health Department - SHDHD
- ❑ Three Rivers Public Health Department - 3RPHD
- ❑ Other _____

If you are a Local Health Department you are now done with this form.

Client Referred to Endoscopy Provider:

Endoscopy Provider Name: _____

Phone: _____ **Fax:** _____

Colonoscopy Scheduled _____/_____/_____

Completed by: _____

Follow Up Action / Findings:

❑ Client needs assistance in finding health care provider

❑ **I have talked with client and received verbal consent from client:**
My health care provider and laboratory, can give results of my FIT Kit and colonoscopy to NCP for payment and quality assurance. No information will be shared with outside sources.

Form Completed By: _____ **Date:** _____

Great Job - You're Done!

First Name: _____ Last Name: _____ Date of Birth: ____/____/____