EFFECTIVE: *October 1, 2024-June 30, 2025*

PRESUMPTIVE ENROLLMENT Healthy Lifestyle Questionnaire

What is PRESUMPTIVE ENROLLMENT?:

- Patient is in your office for services and patient is eligible for Every Woman Matters (EWM).
- Clinic presumes that client is eligible based upon eligibility criteria.
- Clinic will provide services same day of enrollment.
- If client has Permanent Resident Card/Green Card, call EWM to check the SAVE program for eligibility.

Eligibility criteria for enrollment into EWM and/or the Nebraska Colon Cancer Screening Program (NCP):

- Must meet age guidelines (21-74)
- Must not have health coverage that would pay for preventive screening services
- For NCP, client must be a Nebraska resident
- Must be a U.S. Citizen or 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 be lawfully present in the United States. *(i.e. Permanent Resident Card/Green Card)*
- Must meet income guidelines that fall at or below 250% of the Federal Poverty Guidelines

If client is eligible for EWM and/or NCP, please fill out this form.

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	

Effective: July 1, 2024-June 30, 2025

WHAT CLIENTS NEED TO KNOW:

- You must NOT have health insurance that would pay for preventive services.
- Please answer ALL questions.
- Please PRINT clearly. Use a black or blue ink pen. Do not use pencil.
- Screening Card is located on Page 9.

WHAT PROVIDERS NEED TO KNOW:

- Screenings are determined by the provider and based upon how client answers questions on pages 5-8.
- Discuss with the client benefits of healthy lifestyle behaviors.
- Clinics must submit the PRESUMPTIVE ENROLLMENT FORM to the program, but clinics may make a copy of the HLQ as a part of the client chart, if so desired.
- Clinics MUST include the results of the services performed.

Thank you for taking time for your health!

Version: 10/2024

Informed Consent and Release of Medical Information

- **You must read pages 2 and 3 to be a part of the Every Woman Matters Program and/or the Nebraska Colon Cancer Screening Program.**
- **You are NOT able to enroll until all pages are filled out.**

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EVERY WOMAN MATTERS (FEMALES)

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
  - I must be between 21-74 years of age to receive services
  - I cannot be over income guidelines
  - If I have insurance, EWM will only pay after my insurance pays
  - I must re-enroll in EWM every year
  - 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 21-34 years of age, I may be eligible for cervical cancer screening based upon US Preventive Services Task Force and Program Guidelines.
- I know that if I am 35-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and Program Guidelines.
- I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.
- I will talk with my health care provider about how I am going to pay for any tests or services that are not paid by EWM.
- When I receive my Screening Card I will be given an opportunity to make a $5 donation to the program to help other women receive screening services.

NEBRASKA COLON CANCER SCREENING PROGRAM (MALES and FEMALES)

- 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 tests or 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.

 Continue Reading on Page 3 ~ You MUST Sign and Date Page 3 ⇢

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 test 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.

Please Print Your Name (first, middle, last)

Your Signature

month day year
Your Date of Birth

month day year
Date of Your Signature

Be Sure to Print Your Name, Sign and Date This Page ⇢

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)***_____

You're On a Roll.....Continue to Page 5 ⇢

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)*?		❍Yes ❍No ❍DK*
2a. Was your cervix removed?		❍Yes ❍No ❍DK*
2b. Was your **hysterectomy** to treat cervical cancer?		❍Yes ❍No ❍DK*
3. Has your ***mother, sister or daughter*** ever had **breast cancer**?	❍Yes ❍No ❍DK*	When: _____/_____/_____
4. Have **you** ever had breast cancer?	❍Yes ❍No ❍DK*	When: _____/_____/_____
5. Have **you** ever had cervical cancer?	❍Yes ❍No ❍DK*	

COLON

****ONLY females and males 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**?	❍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	❍Yes ❍No ❍DK*
Familial Adenomatous Polyposis (FAP)	❍Yes ❍No ❍DK*
Hereditary Non Polyposis Colorectal Cancer (HNPCC)	❍Yes ❍No ❍DK*
Inflammatory Bowel Disease (IBD)	❍Yes ❍No ❍DK*
Ulcerative Colitis	❍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

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

Client Information & Healthy Lifestyle Questionnaire

Version: 10/2024

INSTRUCTIONS: Please answer each question and PRINT clearly!

DIET & PHYSICAL ACTIVITY

****ONLY females 35+ need to answer the questions in this box**

1. How many cups of **fruit** do you eat in an average day? *(1 cup equals 1 large banana or 1 medium apple)*	❍0 ❍1 ❍2 ❍3 ❍4 ❍5 ❍6+ ❍DK*
2. How many cups of **vegetables** do you eat in an average day? *(1 cup equals 12 baby carrots or 1 ear corn)*	❍0 ❍1 ❍2 ❍3 ❍4 ❍5 ❍6+ ❍DK*
3. Do you eat **fish** at least two times a week?	❍Yes ❍No ❍DK*
4. How many servings of **grain products** do you eat in a day? *(serving equals 1 slice whole wheat bread, 3 cups popped popcorn, 1/2 cup rice/pasta, 3/4 cup oatmeal)*	❍0 ❍1 ❍2 ❍3 ❍4 ❍5 ❍6+ ❍DK*
4a. Of these servings, how many are **whole grain?**	❍Less than half ❍About half ❍More than half ❍DK*
5. Do you drink less than 36 ounces of **beverages with added sugars** weekly? *(3 (12 ounce) cans regular soda, juice, alcohol, specialty drinks)*	❍Yes ❍No ❍DK*
6. Are you currently watching or reducing your **sodium** or **salt** intake?	❍Yes ❍No ❍DK*
7. How many minutes of **physical activity** do you get in a WEEK? *(walking/running, aerobic dancing, water aerobics, general gardening, bicycling)*	_____ Minutes ❍DK*

BLOOD PRESSURE, CHOLESTEROL & DIABETES

****ONLY females 35+ need to answer the questions in this box**

	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	DIABETES
1. Has your doctor, nurse or other health professional **EVER** told you that you have:	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*
2. Do you take any medication prescribed by your doctors **NOW** to lower:	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*
3. During the **past 7 days**, how many days *(including today)* did you take your medication as prescribed:	_____ Days ❍Not Applicable ❍DK*	_____ Days ❍Not Applicable ❍DK*	_____ Days ❍Not Applicable ❍DK*
4. On days you **did not take your medication** as prescribed, please tell us why:	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to take Meds ❍Other _____	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to take Meds ❍Other _____	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to take Meds ❍Other _____
5. Do you check your **BLOOD PRESSURE** when you are not at the doctor's office *(at home, at pharmacy, or at a store, etc.)*?	❍Yes ❍No ❍DK*		
5a. If no, provide reason:	❍No, never told to check ❍No, don't know how to check ❍No, don't have equipment		
5b. If yes, how often do you check your **BLOOD PRESSURE**:	❍Multiple times a day ❍Daily ❍Weekly ❍A few times per week ❍Monthly ❍DK*		
5c. If yes, do you share your **BLOOD PRESSURE** numbers with your doctor that you take at home, the pharmacy or a store?	❍Yes ❍No ❍DK*		

HEART

****ONLY females 35+ need to answer the questions in this box**

1. Have you been **diagnosed** by a healthcare provider as having **any** of these conditions: *(mark all that apply)*	
Coronary Heart Disease/Chest Pain:	❍Yes ❍No ❍DK*
Congenital Heart Defects:	❍Yes ❍No ❍DK*
Heart Failure:	❍Yes ❍No ❍DK*
Stroke/Transient Ischemic Attack (TIA):	❍Yes ❍No ❍DK*
Vascular Disease:	❍Yes ❍No ❍DK*
Heart Attack:	❍Yes ❍No ❍DK*
(females only) Gestational Hypertension:	❍Yes ❍No ❍DK*
(females only) Gestational Diabetes:	❍Yes ❍No ❍DK*
(females only) Pre-Eclampsia/Eclampsia:	❍Yes ❍No ❍DK*
2. Are you taking **aspirin daily** to help prevent a heart attack or stroke?	❍Yes ❍No ❍DK*

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

Client Information & Healthy Lifestyle Questionnaire

Version: 10/2024

INSTRUCTIONS: Please answer each question and PRINT clearly!

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

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. **Women:** How many days in the past year have you had 4 or more alcoholic drinks in a day?	❍Never _____ Days ❍NA* ❍DK*
	3. **Men:** How many days in the past year have you had 5 or more alcoholic drinks in a day?	❍Never _____ Days ❍NA* ❍DK*
	4. During the past 12 months, have you had a **flu shot or flu mist**?	❍No ❍Yes ❍DK*
	4a. If not, please share why?	
	5. Have you had a **pneumonia shot**?	❍No ❍Yes ❍DK*
	6. 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*

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

Client Information & Healthy Lifestyle Questionnaire

Version: 10/2024

INSTRUCTIONS: Please answer each question and PRINT clearly!

SOCIAL DETERMINANTS OF HEALTH

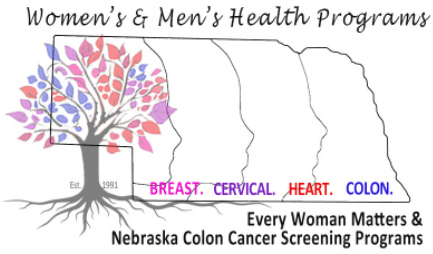
1. Do **you own or use** any of the following types of **computers**? 7a. Desktop/Laptop:	❍Yes ❍No ❍DK* ❍Don't Want to Answer
7b. Smartphone:	❍Yes ❍No ❍DK* ❍Don't Want to Answer
7c. Tablet/Other portable wireless computer:	❍Yes ❍No ❍DK* ❍Don't Want to Answer
2. Do you or any member of your household have **access to the internet**?	❍Yes-by paying a cell phone company / internet service provider ❍Yes-without paying a cell phone company / internet service provider ❍No access to internet in the house, apartment or mobile home ❍DK* ❍Don't Want to Answer
3. During the last **12 MONTHS**, was there a time when you were worried you would **run out of food** because of lack of money or other resources?	❍Yes ❍No ❍DK* ❍Don't Want to Answer
4. Have you ever **missed a doctor's appointment** because of **transportation** problems?	❍Yes ❍No ❍DK* ❍Don't Want to Answer
5. If you are currently using **child care services** please identify the type of services you use, if not, select *Not Applicable*. ***(select all that apply)***	❍Infant (Birth to 11 months) ❍Toddler (11 to 36 months) ❍Preschool (3 to 5 years) ❍After School Care (K-9th Grade) ❍Not Applicable ❍DK* ❍Don't Want to Answer
6. Have you had any of these **child-care related problems** during the past year? ***(select all that apply)***	❍Cost ❍Availability ❍Location ❍Transportation ❍Hours of Operation ❍Other ❍Not Applicable ❍DK* ❍Don't Want to Answer
7. What is your **housing situation**?	❍I have housing ❍I have housing, but I am worried about losing my housing ❍I do not have housing ❍DK* ❍Don't Want to Answer
8. The following will ask about **how safe you feel**:	
8a. How **often** does your partner **physically hurt you**?	❍Never ❍Rarely ❍Sometimes ❍Fairly Often ❍Frequently ❍Don't Want to Answer
8b. How **often** does your partner **insult or talk down to you**?	❍Never ❍Rarely ❍Sometimes ❍Fairly Often ❍Frequently ❍Don't Want to Answer
9. These four items are related to **medicine that you take** for ***any health conditions*** that you might have: 9a. Do you ever forget to take your medicine? 9b. Are you careless at times about taking your medicine? 9c. When you feel better, do you sometimes stop taking your medicine? 9d. If you feel worse (bad) when you take your medicine, do you stop taking it?	❍Yes ❍No ❍Don't Want to Answer ❍Yes ❍No ❍Don't Want to Answer ❍Yes ❍No ❍Don't Want to Answer ❍Yes ❍No ❍Don't Want to Answer

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

Great Job! You're DONE!!

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



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

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.

General Clinical Services

Height: (with shoes off) _____ /_____ ft./in.
Weight: _____ lbs.
Waist Circumference: _____ inches

Note--2 blood pressure readings are required for this visit.

Blood Pressure (1): _____ /_____ mm Hg

Blood Pressure (2): _____ /_____ mm Hg

1. Is client taking blood pressure medication? ❑Yes* ❑No
2. Are you ordering or changing blood pressure medication today? ❑Yes* ❑No
3. Is the client taking cholesterol medication to lower cholesterol? ❑Yes ❑No
   3a. Is it a statin? ❑Yes ❑No ❑Other _____
4. Contact us if you would like your client to get a follow-up visit for a blood pressure re-check *(needs prior approval)* **1-800-532-2227**

*Counsel client on medication adherence for hypertension and check the last box in the section below.

Cardiovascular Risk Reduction Counseling

Check if counseling completed
Female clients 35-64 ONLY

- ❑ Client counseled on low dose aspirin usage to decrease risk for CVD
- ❑ Medication Adherence for Hypertension Counseling

Healthy Behavior Support Services*:
- ❑ Client referred to our clinic SMBP
- ❑ Health Coaches for Hypertension Program
- ❑ Living Well Education
- ❑ National Diabetes Prevention Program (NDPP)
- ❑ Walk & Talk Toolkit (Physical Activity)
- ❑ Tobacco Cessation Counseling
  - ❑ Client Referred to Statewide Quitline at 1-800-QUIT-NOW
  - ❑ Fax Referral to Statewide Quitline at 1-800-QUIT-NOW
  - ❑ Client Refused

Completion of the GREEN section is equivalent to submitting claims for Risk Reduction Counseling and SDOH Assessment.

❑SDOH Assessment Complete

❑Unite Us Network Referral Made

CVD/Diabetes Screening

Female clients 35-64 ONLY

Labs can only be done in conjunction with breast and/or cervical screening services.

Bloodwork Ordered: ❑Yes ❑No

Client fasted 9 hrs: ❑Yes ❑No
Blood Draw Date: _____/_____/_____

Blood draw needs to be within 30 days of today's visit

Cholesterol does NOT need to be fasting.

Total Cholesterol: _____ mg/dl
HDL (value not ratio): _____ mg/dl
LDL (value not ratio): _____ mg/dl
Triglycerides: _____ mg/dl

ALL clients 35+ are now eligible for A1c!

A1c *(preferred)*: _____
OR
Blood Glucose: _____ mg/dl
(acceptable)

Colon Cancer Screening

Female/Male clients 45-74 ONLY

- ❑ Clinic will assist client with completing appropriate CRC screening
- ❑ Clinic would like NCP to follow up with client to assess for CRC screening and provide appropriate screening test
- ❑ Client is not due for CRC screening

Reminders to Clinician:
- **If a clinic home based stool kit is given, and the results are positive, NCP can not enroll for a colonoscopy.**
- **NCP is a screening program NOT a diagnostic program.**

****MUST be an approved contracted provider to receive reimbursement.**

Mammography

Female clients 40-64 ONLY

- ❑ Mammogram ordered
  Give client Mammography Order Form
- ❑ Mammogram not ordered
  If not performed, mark or list reason:
  - ❑ Not age appropriate
  - ❑ Client not at risk (client 40-49)
  - ❑ Other _____

Clinical Breast Exam

Female clients 21-64

Finding:
- ❑ Negative/Benign
- ❑ Client reports breast symptoms
  - ❑ Suspicious for **BREAST** malignancy
    Immediate follow up is required beyond diagnostic mammogram
- ❑ Not Performed

Client Risk for Breast Cancer

Female clients 21-64

- ❑ Average Risk **Definitions on back*
- ❑ High Risk **Definitions on back*
- ❑ Not Assessed

Screening Pap

Female clients 21-64

- ❑ Pap test performed
  (place red & white EWM sticker on lab requisition)
- ❑ Pap test not performed ***Mark/list reason***
  - ❑ Hysterectomy *(with cervix removed)* not due to cervical cancer
  - ❑ _____
- ❑ HPV test performed
  (place red & white EWM sticker on lab requisition)
- ❑ HPV test not performed

Pelvic Exam

Female clients 21-64

Finding:
- ❑ Negative/Benign
- ❑ Visible Suspicious **CERVICAL** lesion
- ❑ Not Performed

Client Risk for Cervical Cancer

Female clients 21-64

- ❑ Average Risk **Definitions on back*
- ❑ High Risk **Definitions on back*
- ❑ Not Assessed

Date of Service for Office Visit _____/_____/_____

_____ **Clinician Name** *(**PRINT** full name-do not abbreviate)*

_____ **Clinic Name and City** *(**PRINT** full name-do not abbreviate)*

Program Services

Version: 10/2024

EWM/NCP follows the U.S. Preventive Services Task Force (USPSTF) guidelines regarding screening intervals/recommendations. USPSTF information can be found at:

https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

Program eligibility guidelines may differ slightly.

USPSTF Screening Guidelines

Cervical Cancer	Breast Cancer
Women 21-29 **Grade: A** Screen with cytology (Pap smear) every 3 years.	**Women aged 40 to 74 years** **Grade: B** Biennial screening mammography for women aged 40 to 74 years.
Women 30-65 **Grade: A** Screen with cytology every 3 years or co-testing (cytology/HR-HPV testing) every 5 years or screen every 5 years with HR-HPV alone.	

Colon Cancer

Men and Women 45-74 **Grade: B**

Screening for Colon Cancer with any of the following tests:

- **FOBT/FIT Annually***
- **Colonoscopy every 10 years** *

Other approved tests by USPSTF: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2

Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.

CERVICAL Risk Assessment Definitions:

- **Average Risk** should be reported if risk was assessed and determined to be average risk
- **High/Increased Risk** should be reported if risk was assessed and determined to be high risk *(prior DES exposure and immunocompromised patients)*
- **Not Assessed** should be reported if risk was not assessed, family history was not taken, and/or genetic testing was not done.

BREAST Risk Assessment Definitions:

- **Average Risk** should be reported if risk was assessed and determined to be average risk
- **High/Increased Risk** should be reported if risk was assessed and determined to be high risk *(Women with BRCA mutation, a first-degree relative who is a BRCA carrier, a lifetime risk of 20-25% or greater as defined by risk assessment models, radiation treatment to the chest between ages 10-30, or personal or family history of genetic syndromes like Li-Fraumeni syndrome)*
- **Not Assessed** should be reported if risk was not assessed, family history was not taken, and/or genetic testing was not done.

If you have questions:

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/EWM || www.dhhs.ne.gov/CRC
Email: dhhs.ewm@nebraska.gov (Every Woman Matters) || dhhs.nccsp@nebraska.gov (Nebraska Colon Program)

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

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

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