



PRESUMPTIVE

Client Enrollment

EVERY WOMAN MATTERS

Where to Begin

- A PRESUMPTIVE ENROLLMENT Healthy Lifestyle Questionnaire (PE-HLQ) is required to be filled out for each client.
- The PE-HLQ should be filled out **PRIOR** to services being offered.
- Completed form should be returned to EWM **after** the office visit.

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

# of People in Household	Yearly Income	
	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

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

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:

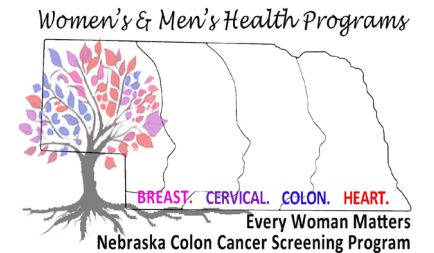
- Screenings are determined by the provider and based upon how client answers questions on pages 5-8.
- Discuss with the client benefits of healthy lifestyle behaviors.
- Clinics must submit the PRESUMPTIVE ENROLLMENT FORM to the program, but clinics may make a copy of the HLQ as a part of the client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

Thank you for taking time for your health!

Version: 10/2024

How can I help my patients access Every Woman Matters?

- ▶ Know what services are covered by the program
- ▶ Keep PE-HLQ's on hand in your office for patients to fill out.
- ▶ Assist patients in completing the forms if needed
- ▶ Clinic presumes that client is eligible based upon eligibility criteria.
- ▶ Clinic to provide services same day as enrollment
- ▶ If client has Permanent Resident Card/Green Card, [email EWM](#) to check the SAVE program for eligibility. Depending upon staff availability this will be done on the same day the request is received but know that may not always happen.
- ▶ If the client is experiencing an issue such as a breast lump or has had an abnormal Pap she could be eligible for immediate services through our diagnostic enrollment. Instructions and forms can be found here: dhs.ne.gov/ewmforms

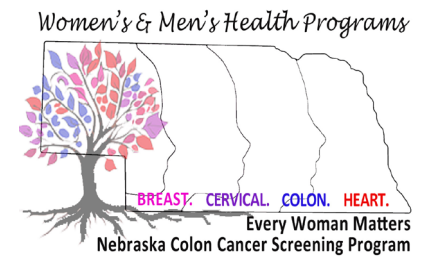


Obtaining PRESUMPTIVE ENROLLMENT Healthy Lifestyle Questionnaires

- ▶ Online PE-HLQs are available at dhhs.ne.gov/ewm. Click the “Presumptive Enrollment Healthy Lifestyle Questionnaire” tab
- ▶ Keep PE-HLQ's on hand in your office* by downloading copies from our website. Materials can be downloaded at dhhs.ne.gov/ewmforms



Program Eligibility



Informed Consent and Release of Medical Information

Version: 10/2024

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/retesting 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 refer me to a care network called Unite Us. Unite Us will link me to community agencies close to me and with other organizations as required to receive treatment resources.
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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.

• I am a citizen of the United States.
 • I am a qualified alien under the federal Immigration and Nationality Act, § U.S.C. 1301 et seq on January 1, 2009, and am lawfully present in the United States. I am attaching a front and back copy of my Permanent Resident Card (Green Card) documentation. (For example, Permanent Resident Card (Green Card))

I hereby attest that my response and the information provided on this form and any of the benefits are true, complete, and accurate and I understand that this information may be shared with other organizations as required to receive treatment resources.

Please Print Your Name (first, middle, last) _____
 Your Date of Birth (month, day, year) _____

Be Sure to Print _____

Client Information & Healthy Lifestyle Questionnaire

Version: 10/2024

INSTRUCTIONS: ALL Clients need to fill this page out!

First Name: _____ Middle Initial: _____ Last Name: _____
 Maiden Name: _____ Marital Status: Single Married Divorced Widowed
 Birthdate: _____/_____/_____ 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
 Yes, it is okay to text my cell phone.
 Yes, I want to receive program information by email. My email is: _____
 No, I do not want to receive program information by email.

DEMOGRAPHICS

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 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 grad Some college or higher Don't know

How did you hear about the program: Doctor/Clinic Family/Friend Age 50+ Newspaper/Radio/TV I am a Current/Previous Client Social Media (Facebook/Instagram, etc.)

INCOME & INSURANCE

I may be required to show proof that my income is within the program income guidelines when I am contacted. 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. Forms will be returned if you do not have any income, please write 50 in the income space.

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

Do you have insurance? Yes No If yes, is it:
 Medicare (for people 65 and over)
 Part A and B
 Medicaid (full coverage)
 Catastrophic insurance
 Health Marketplace
 Private Insurance (please list) _____

4 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

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

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 1st degree relatives, excluding yourself, (parents, brothers, sisters, children) have been told they have polyps in the colon? 0 1 2 3+ DK*
 3. 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*
 4. What kind of cancer did they have?
 5a. What type of cancer did they have?
 5b. What type of cancer did they have?
 6. Have you ever been told that you have had polyps in the colon?
 6a. How many polyps did you have?
 6b. How many polyps did you have?
 7. Have you ever had any of the following tests? (Dates and results need to be marked):
 Sigmoidoscopy Yes No DK* Result: Normal Abnormal DK*
 Colonoscopy Yes No DK* Result: Normal Abnormal DK*
 Double Contrast Barium Enema (DCBE) Yes No DK* Result: Normal Abnormal DK*
 8. Have you ever been told by a doctor, nurse, or other health professional that you have had:
 Crohn's Disease Yes No DK* Result: Normal Abnormal DK*
 Familial Adenomatous Polyposis (FAP) Yes No DK* Result: Normal Abnormal DK*
 Inflammatory Bowel Disease (IBD) Yes No DK* Result: Normal Abnormal DK*
 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: _____
 First Name: _____ Date of Birth: _____/_____/_____ Phone: _____
 Last Name: _____

Keep Moving for Your Health! 5

Determining Eligibility

Information gathered from the client's PE-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 21-64



United States
Residents



Income Eligible

Who is Eligible – Uninsured Clients



Uninsured Clients ages 21-64

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 at 800-532-2227 to determine enrollment eligibility.
- Diagnostic clients with private insurance may still be eligible for EWM! Call to speak with a staff nurse about enrollment.

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 can be found at <http://dhhs.ne.gov/ewmforms>

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.

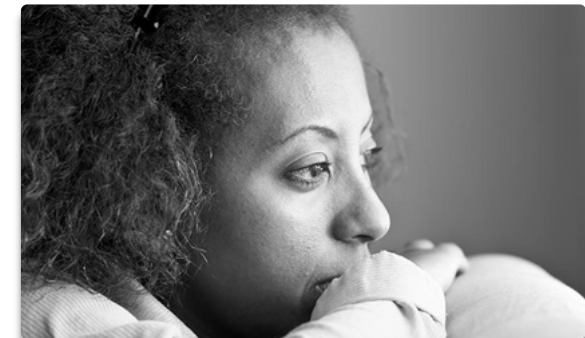
Other Factors that Determine Eligibility



USPSTF Guidelines



Screening History



Personal History

Determining Eligibility– USPSTF Guidelines



USPSTF Guidelines

Is it appropriate for the client to be screened?

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: <ul style="list-style-type: none"> • FOBT/FIT Annually* • Colonoscopy every 10 years * 	
<i>Other approved tests by USPSTF: https://www.uspreventiveservicestaskforce.org/Page/Document/Recommendation-StatementFinal/colorectal-cancer-screening2</i>	
<i>*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.</i>	

Screening services covered for reimbursement must adhere to the U.S. Preventive Services Screening Task Force (USPSTF) Guidelines

www.uspreventiveservicestaskforce.org/

Determining Eligibility – Screening History



Screening History

Services are determined by screening dates that the clients have self reported in their HLQ and past Every Woman Matters records.

An Every Woman Matters Screening Covers:

- Clinical Breast Exams
- Screening mammograms for women 40-64 every 2 years
- Screening Pap Tests for women 21-64 every 3 years with cytology or every 5 years with cytology/HPV
- Cardiovascular screening for women 35-64 in conjunction with an eligible breast or cervical screening
 - Cholesterol, Triglycerides, A1c/Blood Glucose

Existing clients are automatically sent HLQ's a month prior to their due dates as determined by previous program records.

Clients who are deemed not due for services will be sent notice via mail.

Determining Eligibility – Personal History



Personal History

Does the client have a personal history of cancer?

Screening mammograms/Pap tests may be performed yearly if the client has had a personal history of breast/cervical cancer.

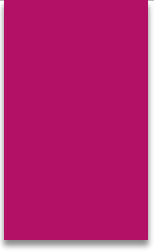
Clients with a documented personal history of BRCA1 or BRCA2 gene mutations only:

Clients age 25-39: Eligible for annual breast MRI screening (A screening mammogram is not reimbursed by EWM)

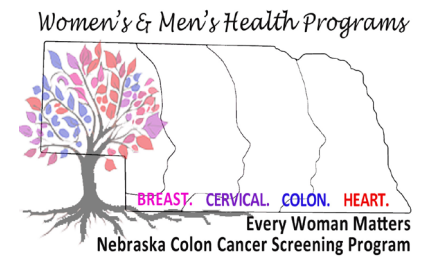
- Initiation of screening would be individualized based on earliest age of onset in family
- MRI must be preapproved by EWM

Clients age 40-64: Annual screening mammogram at the time of her EWM screening visit or immediately afterward,

- Breast MRI Screening alternating 6 months after the screening mammogram



Screening Card



Screening Cards

- ▶ Page 9 of the PE-HLQ is the Screening Card. Once the clinic deems the client is approved for appropriate services the clinic fills it out.
- ▶ The screening card lets the client and the provider know the services covered by the program.
- ▶ Provider may:
 - Discuss the HLQ answers with the client
 - Fax referral, at clients request, to Tobacco QuitLine *if applicable (See NE Tobacco Quitline Lesson for more information)
 - Request home-based colon cancer screening test kit (FIT Test) to be sent to client *if applicable
 - Give instructions for next steps for screening

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Program Services

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 (diagnostic mammogram required beyond)

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

(placed red & white FEMM sticker on lab requisition)

Pap test not performed

Mark/Jist reason

Hysterectomy (with cervix removed) not due to cervical cancer

HPV test performed (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

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

OR Glucose: _____ mg/dl (acceptable)

Colon Cancer Screening

Female/Male clients 45-74 ONLY

Client with kit still within 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:

- Kit with stool 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 receive reimbursement.**

General Clinical Services

Height (with shoes off) _____ ft./in.

Weight _____ lbs.

Waist circumference: _____ inches

Male-20 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

3b. Is it a statin? Yes No

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

Female clients 35-64 ONLY

Client counseled on low dose aspirin usage to decrease risk for CVD

Client counseled on adherence for Hypertension Counseling

Client counseled on adherence for Hypertension Counseling

Client referred to our clinic SM/np Health Coaches for Hypertension Program

Client referred to our clinic SM/np National Diabetes Prevention Program (NDPP) Walk & Talk Toolkit (Physical Activity)

Client referred to our clinic Statewide Quitline at 1-800-QUIT-NOW

Client referred to Statewide Quitline at 1-800-QUIT-NOW

Client Referred

Completion of the general services is required to submit a claim for Risk Reduction Counseling and SDOH Assessment.

SDOH Assessment Complete

Unite Us Network Referral Made

Date of Service for Office Visit _____

Clinician Name (P/NW/ full name-do not abbreviate) _____

Clinic Name and City (P/NW/ full name-do not abbreviate) _____

Screening Cards

In order to be reimbursed for services:

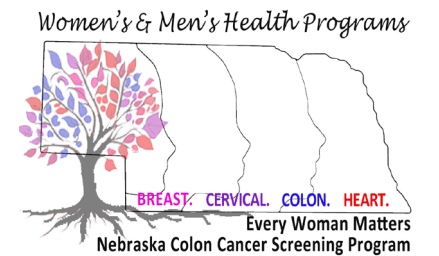
- ▶ The client must be seen at a clinic/provider that has been approved by EWM
- ▶ Provider determines eligibility for services
- ▶ Screening cards must be filled out completely and returned to EWM within 2 weeks

Other items to remember:

- ▶ If eligible, give the client a [Mammography Order Form](#) to bring to their radiology appointment

<p>General Clinical Services</p> <p>Height: (with shoes off) _____ / _____ ft./in. Weight: _____ lbs. Waist Circumference: _____ inches <i>Note-2 blood pressure readings are required for this visit.</i> Blood Pressure (1): _____ / _____ mm Hg Blood Pressure (2): _____ / _____ mm Hg</p> <ol style="list-style-type: none"> Is client taking blood pressure medication? <input type="checkbox"/> Yes* <input type="checkbox"/> No Are you ordering or changing blood pressure medication today? <input type="checkbox"/> Yes* <input type="checkbox"/> No Is the client taking cholesterol medication to lower cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No 3a. Is it a statin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ Contact us if you would like your client to get a follow-up visit for a blood pressure re-check (<i>needs prior approval</i>) 1-800-532-2227 *Counsel client on medication adherence for hypertension and check the last box in the section below. <p>Cardiovascular Risk Reduction Counseling Check if counseling completed Female clients 35-64 ONLY</p> <p><input type="checkbox"/> Client counseled on low dose aspirin usage to decrease risk for CVD <input type="checkbox"/> Medication Adherence for Hypertension Counseling</p> <p>Healthy Behavior Support Services*:</p> <p><input type="checkbox"/> Client referred to our clinic SMBP <input type="checkbox"/> Health Coaches for Hypertension Program <input type="checkbox"/> Living Well Education <input type="checkbox"/> National Diabetes Prevention Program (NDPP) <input type="checkbox"/> Walk & Talk Toolkit (Physical Activity) <input type="checkbox"/> Tobacco Cessation Counseling <input type="checkbox"/> Client Referred to Statewide Quitline at 1-800-QUIT-NOW <input type="checkbox"/> Fax Referral to Statewide Quitline at 1-800-QUIT-NOW <input type="checkbox"/> Client Refused</p> <p><i>Completion of the GREEN section is equivalent to submitting claims for Risk Reduction Counseling and SDOH Assessment.</i></p> <p><input type="checkbox"/> SDOH Assessment Complete <input type="checkbox"/> Unite Us Network Referral Made</p>	<p>CVD/Diabetes Screening Female clients 35-64 ONLY</p> <p><i>Labs can only be done in conjunction with breast and/or cervical screening services.</i></p> <p>Bloodwork Ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No Client fasted 9 hrs: <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Draw Date: _____/_____/_____</p> <p><i>Blood draw needs to be within 30 days of today's visit</i></p> <p>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</p> <p>ALL clients 35+ are now eligible for A1c! A1c (preferred): _____ OR Blood Glucose: _____ mg/dl (acceptable)</p>	<p>Mammography Female clients 40-64 ONLY</p> <p><input type="checkbox"/> Mammogram ordered Give client Mammography Order Form</p> <p><input type="checkbox"/> Mammogram not ordered If not performed, mark or list reason: <input type="checkbox"/> Not age appropriate <input type="checkbox"/> Client not at risk (client 40-49) <input type="checkbox"/> Other _____</p> <p>Clinical Breast Exam Female clients 21-64</p> <p>Finding: <input type="checkbox"/> Negative/Benign <input type="checkbox"/> Client reports breast symptoms <input type="checkbox"/> Suspicious for BREAST malignancy <i>Immediate follow up is required beyond diagnostic mammogram</i></p> <p><input type="checkbox"/> Not Performed</p> <p>Client Risk for Breast Cancer Female clients 21-64</p> <p><input type="checkbox"/> Average Risk *Definitions on back <input type="checkbox"/> High Risk *Definitions on back <input type="checkbox"/> Not Assessed</p>
<p>Date of Service for Office Visit _____/_____/_____</p> <p>Clinician Name (PRINT full name-do not abbreviate) _____</p>	<p>Clinic Name and City (PRINT full name-do not abbreviate) _____</p>	<p>Screening Pap Female clients 21-64</p> <p><input type="checkbox"/> Pap test performed (place red & white EWM sticker on lab requisition)</p> <p><input type="checkbox"/> Pap test not performed Mark/list reason</p> <p><input type="checkbox"/> Hysterectomy (with cervix removed) not due to cervical cancer <input type="checkbox"/> _____</p> <p><input type="checkbox"/> HPV test performed (place red & white EWM sticker on lab requisition)</p> <p><input type="checkbox"/> HPV test not performed</p> <p>Pelvic Exam Female clients 21-64</p> <p>Finding: <input type="checkbox"/> Negative/Benign <input type="checkbox"/> Visible Suspicious CERVICAL lesion <input type="checkbox"/> Not Performed</p> <p>Client Risk for Cervical Cancer Female clients 21-64</p> <p><input type="checkbox"/> Average Risk *Definitions on back <input type="checkbox"/> High Risk *Definitions on back <input type="checkbox"/> Not Assessed</p>

Frequently Asked Questions



EWM FAQ

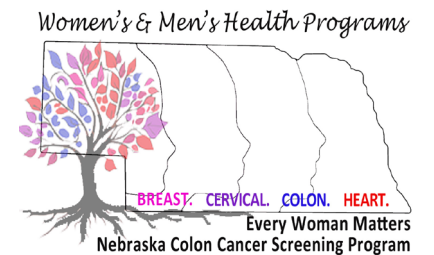
▶ **What if the clients screening has an abnormal result?**

Diagnostic testing may be covered per ASCCP Consensus Guidelines and NCCN Clinical Practice Guidelines. See [provider manual](#) for details.

If client is enrolled for screening through EWM, then the provider may continue with appropriate diagnostic testing. Clinic is responsible for returning completed "Follow-Up and Treatment Plan" form, Page 3 of the Diagnostic Enrollment.

▶ **What if the client needs a screening MRI?**

The provider must submit a request for MRI using the Breast Follow-Up and Treatment Plan for, Page 4 (Breast Diagnostic Enrollment).



Additional Questions Regarding PRESUMPTIVE ENROLLMENT?

Contact Every Woman Matters:

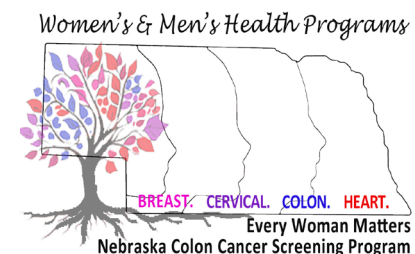
Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/womenshealth web

dhhs.ewm@nebraska.gov email



NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES