Version: 10/2024

STI/STD Assistance Form

****FOR NEBRASKA RESIDENTS ONLY****
Ages 18+: STI/STD Screening Only - Office visit **ONLY** covered for Women and Men

**If client is 21+ and needs cervical cancer screening, fill out the Healthy Lifestyle Questionnaire:
https://cip-dhhs.ne.gov/redcap/surveys/?s=R3PKPPHAJ9XED84K

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

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

301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227 - www.dhhs.ne.gov/womenshealth

DEMOGRAPHICS

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 (_____)_____		**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)***_____

Continue to Page 2 ⇢ ⇢ ⇢

Informed Consent and Release of Medical Information

Version: 10/2024

■ **You must read and sign page 2**

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- I want to be a part of the **STI/STD Assistance Program.** I know:
  - The STI/STD Assistance Program pays for the cost of an office visit in which STD testing is done. It does not pay for the cost of STD testing and handling, follow up or treatment
  - I cannot be over income guidelines
  - I cannot have insurance, Medicare Part B, Medicaid Full Coverage, or an HMO
  - I will notify the STI/STD Assistance Program if I do not wish to be a part of this program anymore
- I will talk with the clinic about how I am going to pay for any tests or services that are not paid by the program.
- I will talk with my healthcare provider about the test(s) and understand possible side effects or discomforts.
- 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 the program, 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 exams, follow up exams, and/or treatment to EWM.
- To assist me in making the best health care decisions, the STI/STD Assistance Program 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 the program 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.

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	month / day / year
Date of Your Signature	Your Date of Birth

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

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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*	
4. Have **you** ever had breast cancer?	❍Yes ❍No ❍DK*	When: _____/_____/_____
5. Have **you** ever had cervical cancer?	❍Yes ❍No ❍DK*	When: _____/_____/_____

The office visit reimbursement is to allow access to a health visit to capture testing for STI/STD. General clinical services can be provided at the same time as STI/STD testing, however, there is no additional reimbursement outside of the office visit.

❍STI/STD test done during this office visit:
- ❍Chlamydia
- ❍Gonnorrhea
- ❍Syphilis

_____

Clinician Name Please write full name - do no abbreviate

_____

Clinic Name

_____

Date of Service for Office Visit

_____

City

Quick Claims will be entered for all STI Office Visits and processed at current fiscal year rates for EWM.

Patient Acct. Number for Quick Claim: _____