STI/STD ASSISTANCE

Enrollment & Testing

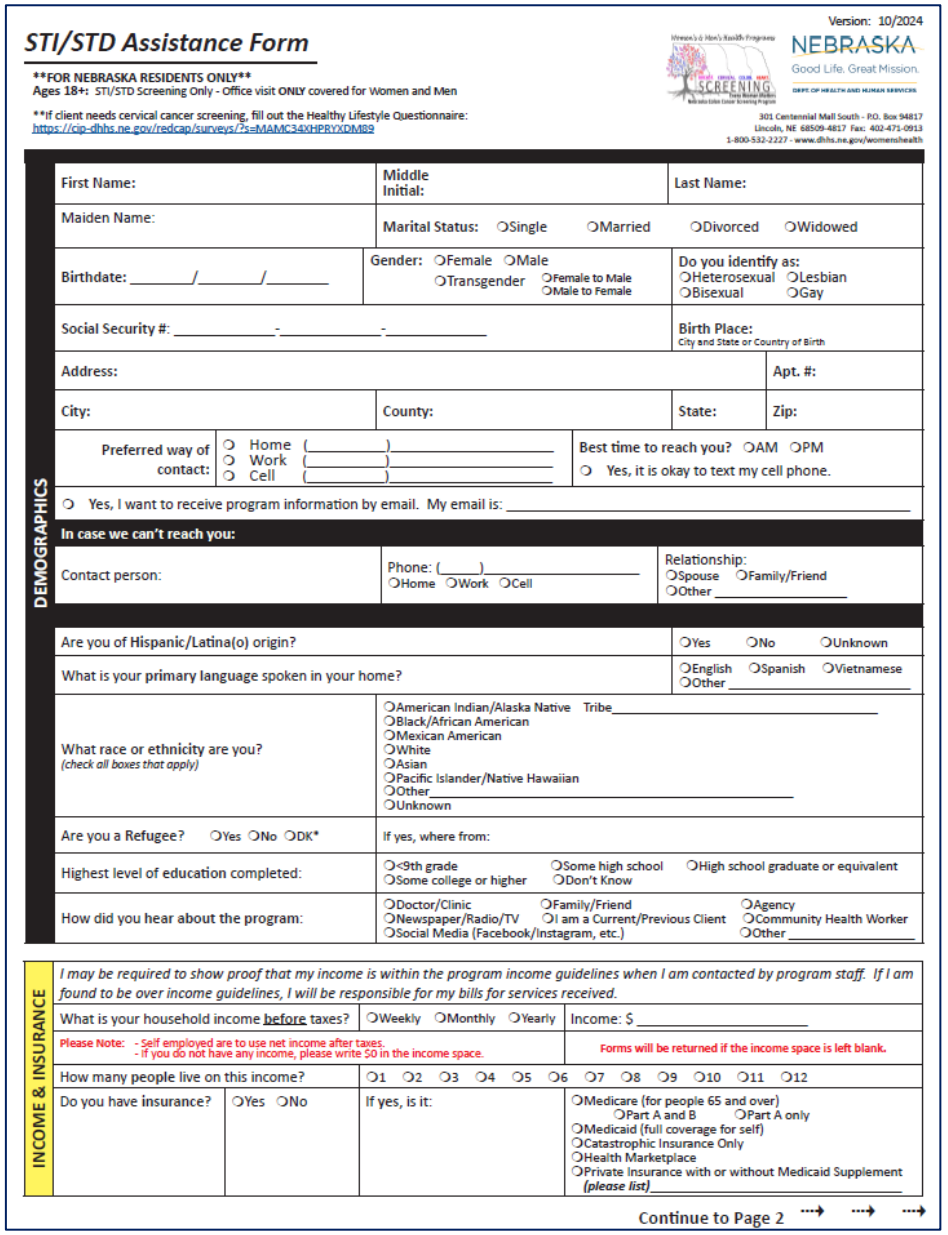
Who can participate?

The STI/STD Assistance Program is for:

NEBRASKA RESIDENTS ONLY

Ages 18+:

- STD Screening Only: Office visit **only** covered for Women and Men



STI/STD Assistance Form

Version: 10/2024

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

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

**If client needs cervical cancer screening, fill out the Healthy Lifestyle Questionnaire:
https://cip-dhhs.ne.gov/redcap/surveys/?s=MAMC34XHPRYXDM89

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 ⇢ ⇢ ⇢

STI/STD Assistance Process Overview

Woman/Man in need of STI/STD Services

- Healthcare staff determine service eligibility

Woman/Man determined eligible for services

- Download the STI/STD Assistance Form
- Complete the form in its entirety

Services Provided

- Send STI/STD Assistance Form to WMHP

Eligibility

STI/STD Assistance Checklist

1. Females and Males ages 18 and up in need of an STI/STD testing assistance.
2. STI/STD Assistance Form completed in its entirety
   - Incomplete forms will be returned to the provider office
3. Client is a Nebraska Resident
4. Medical Release Form is signed and dated by patient (this includes client listing their date of birth and printing their name).
5. Services provided:
   - Office Visit is the only service that is reimbursable.
   - General clinical services can be provided at the same time as STI/STD testing, however, there is no aditional reimbursement outside of the office visit.
   - Page 3 to be completed by provider.

Women's & Men's Health Programs

BREAST. CERVICAL. COLON. HEART.

Every Woman Matters

Nebraska Colon Cancer Screening Program

Determining eligibility

It is the **provider's responsibility** to make sure that the client is eligible for program services.

This allows clients to be seen at the time of their enrollment STI/STD Assistance.

The following guidance will help you down the road of presumptive eligibility…

Who is Eligible

Men and Women
Ages 18+

Must be a
Nebraska Resident

STI/STD Screening Visit

Screening Visit

STI/STD Screening Covers:

- Office visit covered for women AND men ages 18+ for STD screening (chlamydia, gonorrhea, syphilis) as needed

If a woman is in need of screening for breast or cervical cancer screening or is experiencing symptoms suspicious for cancer, clinic should enroll her in EWM. (See EWM Screening Eligibility/Enrollment or EWM Diagnostic Eligibility/Enrollment information)

STI/STD Screening Visit

Screening Visit

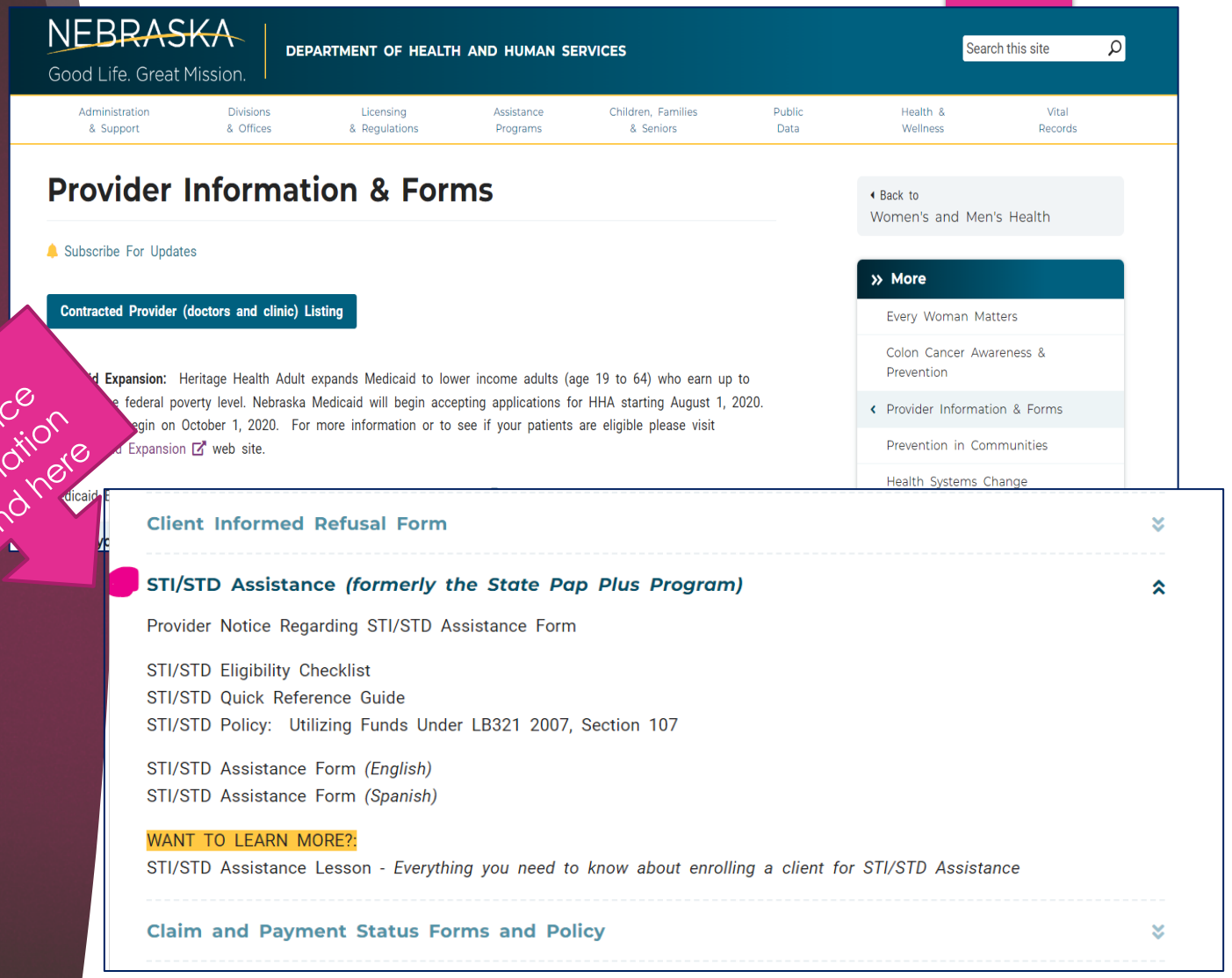
A STI/STD Screening Covers *(con't)*:

- Clients are also eligible for:
  - Clinical Breast Exam (if abnormal, client may be eligible for Breast Diagnostic Follow Up)
  - 2 Blood Pressure Screenings
  - Height/Weight
  - Referral to Nebraska Quitline (if tobacco user)

Website:

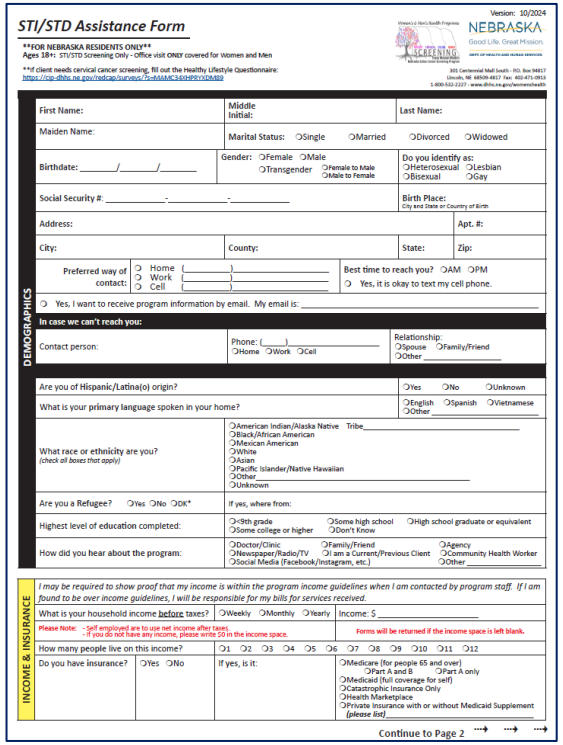
STI/STD Assistance Information

Forms may be downloaded at: www.dhhs.ne.gov/ewmforms



STI/STD Assistance Form - Client Responsibility

Clients are to fill out pages 1-2 and top of page 3 in their entirety



STI/STD Assistance Form

Version: 10/2024

NEBRASKA
Good Life. Great Mission.

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

**If client needs cervical cancer screening, fill out the Healthy Lifestyle Questionnaire:
https://cgi-dhhs.ne.gov/redcap/surveys/?s=AAAAKC3EHHPRYDMB8

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.

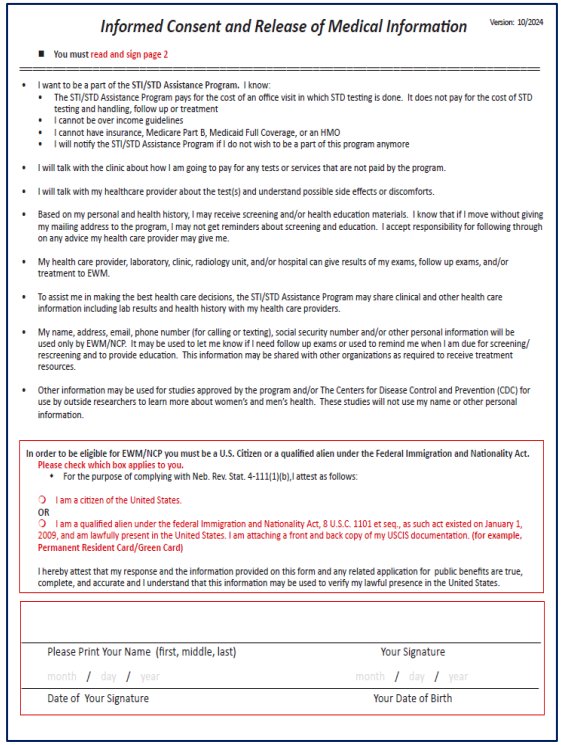
What is your household income before taxes? ○Weekly ○Monthly ○Yearly | Income: $ _____

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

- 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:

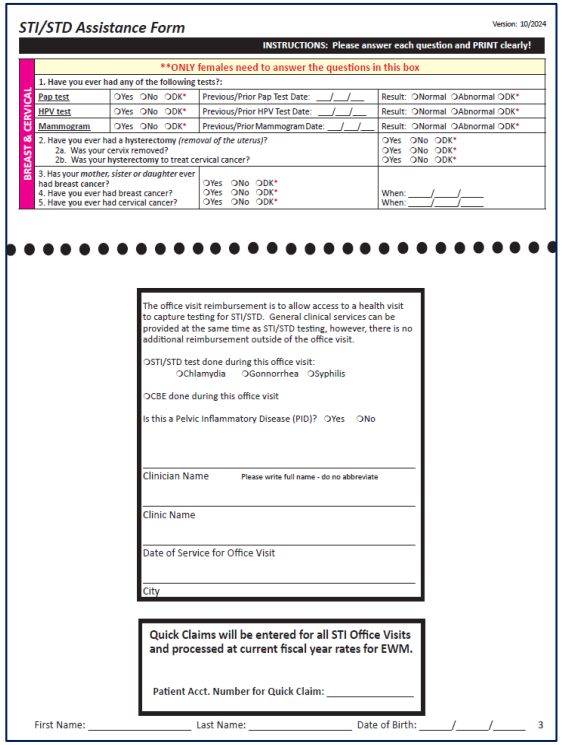
○ I am a citizen of the United States.
OR
○ I am a qualified alien under the federal Immigration and Nationality Act, 8 U.S.C. 1101 et seq., as such act existed on January 1, 2009, and am lawfully present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, 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



STI/STD Assistance Form

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

○CBE done during this office visit

Is this a Pelvic Inflammatory Disease (PID)? ○Yes ○No

Clinician Name Please write full name - do no abbreviate

Clinic Name

Date of Service for Office Visit

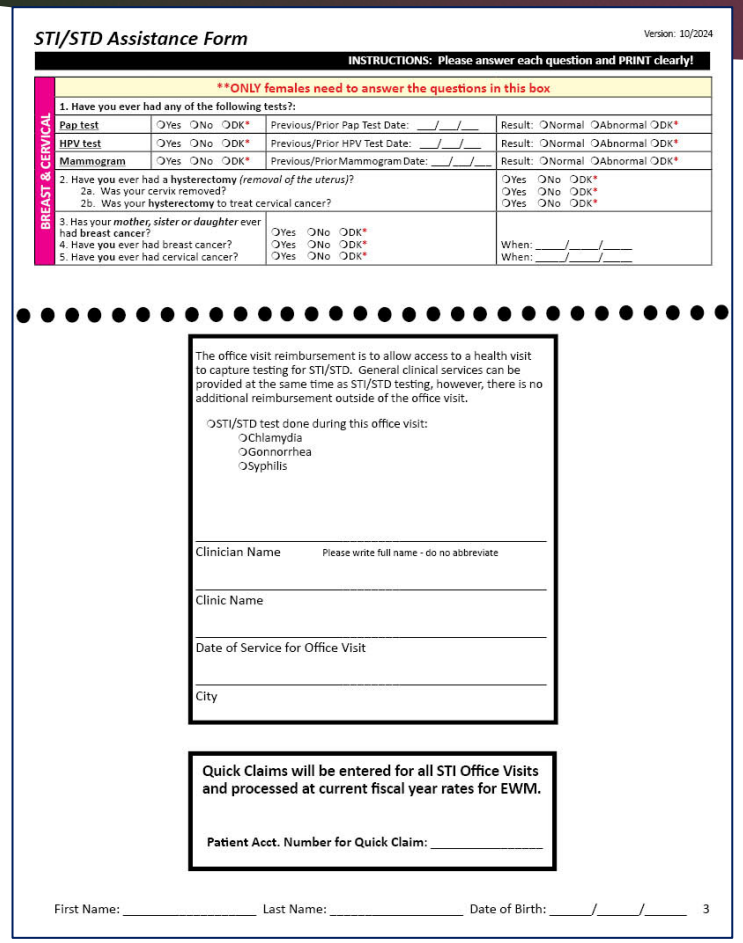
City

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: _____

First Name: _____ Last Name: _____ Date of Birth: ____/____/____ 3

STI/STD Assistance Form - Provider Responsibility



STI/STD Assistance Form

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: _____

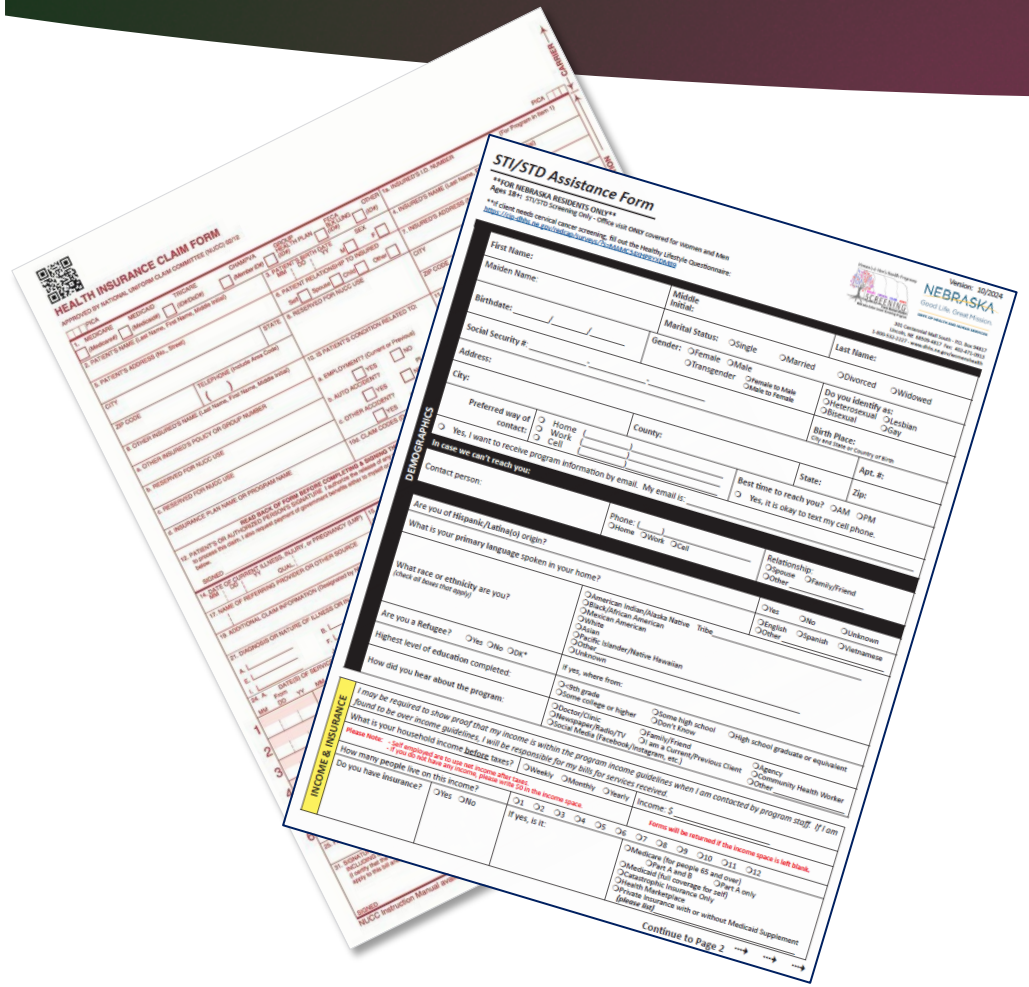
First Name: _____ Last Name: _____ Date of Birth: _____/_____/_____ 3

The provider should complete:

- STI/STD information
- Clinician information
- Date of Service
- Quick Claim Section

Note: STI/STD Assistance Forms must be submitted within 60 days to be reimbursed for services

STI/STD Assistance Form - Provider Responsibility



The following should be returned to EWM within **two weeks** of service:

- STI/STD Assistance Form

QUICK REFERENCE GUIDE FOR PROVIDERS

Qualifying Criteria Guide – **STI/STD ASSISTANCE**	
Gender:	**Females and Males**
Age:	**18+**
Residency:	**Must be a Nebraska Resident**
Health Status:	Client must need STI/STD Assistance The **only** reimbursable service using the STI/STD Assistance Form is an **OFFICE VISIT**.
Forms:	**STI/STD Assistance Form (https://dhhs.ne.gov/EWMForms)** Only forms printed 2024 are accepted *(Date found in upper right-hand corner)*
Enrollment:	1. Complete STI/STD Assistance Form (Incomplete forms will be returned) 2. Clinic to follow guidance regarding presumptive eligibility. 3. Page 3 to be completed by clinic: 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. 4. Send completed form to Women's and Men's Health Program (WMHP)

STI/STD Assistance Form FAQ

- **Can the client fill out the form at the time of their office visit or does he/she need to be enrolled ahead of time?**
  The client can fill out the form at the time of the office visit or they can fill out the enrollment ahead of time. It is up to the provider office. As long as the client meets eligibility requirements they are able to be seen immediately.

- **Does EWM pay for STI/STD screening?**
  EWM does **NOT** pay for STD screening. Filling out the STI/STD Assistance Form will pay for the office visit for STI/STD screening.

- **What if the clients clinical breast exam has an abnormal result?**
  Additional testing may be covered per ASCCP Consensus Guidelines and NCCN Clinical Practice Guidelines. See Provider Participation Manual for details.

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

Additional Questions regarding the STI/STD Assistance Form?

Contact an Every Woman Matters representative:

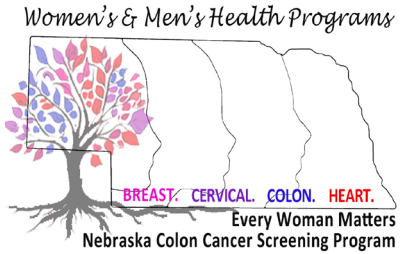
Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/womenshealth web

dhhs.ewm@nebraska.gov email



NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES