DUPAGE COUNTY
HEALTH DEPARTMENT
Everyone, Everywhere, Everyday

111 N. County Farm Rd., Wheaton, IL 60187

Illinois Breast and Cervical Cancer Screening Program "Why Wait?"
Telephone (630) 221-7150 Fax (630)510-5415

The DuPage County Health Department "Why Wait?" Program provides free mammograms and pap smears for uninsured/underinsured women who live in DuPage County. Some clients may require additional testing/treatment not covered by the "Why Wait?" Program, therefore, it is important for clients to also apply for Access DuPage.

Please submit a completed application with the following "Proofs":

1. **Copy of your Access DuPage Card (if applicable).**
2. **Copy of state ID, driver's license, or passport.**
3. **Proof of household income.** (Examples of proof of income may include, but, not limited to: Two or more paystubs received in the last three months, letter of unemployment income, signed letter from your employer indicating amount you are paid per hour and number of hours per week, record of self-employment income/expenses, and letter of spousal and/or child support income)

Participation in the "Why Wait?" Program is not based on income. However, the Illinois Department of Public Health requires this information. Omission of any of the above "Proofs" may result in your application being denied. Applications need to be renewed every year in order to receive services. Some applicants in order to receive services, may require special approval.

Please mail the completed forms and photocopies of your "Proofs" to

DuPage County Health Department
Attn: "Why Wait?"
111 N. County Farm Rd.
Wheaton, Il 60187
Or
Fax to (630) 510-5415 SECURE LINE

The "Why Wait?" Program will contact you when your application has been approved. You can check on the status of your application by calling us at (630) 221-7150.

Thank you for your interest in the Illinois Breast and Cervical Cancer Screening Program.

Illinois Breast and Cervical Cancer Program
Eligibility Determination Form

Shaded area is for IBCCP office use only

☐ New Client Registration Date: _____	☐ Established Client Annual Date: _____	☐ Navigation Only Date: _____	Cornerstone # _____

Name: _____

Previous Last Name: _____

Age: _____ Birth Date: _____/_____/_____

Address: _____

City: _____ State: _____

Zip Code: _____ County: _____

Home Phone: _____

Cell Phone: _____

Day Phone: _____

Medical/Insurance Coverage: ***Check all that apply.***

☐ Medicare Part B – Not eligible for IBCCP
☐ Medicaid ID number _____
☐ I DO NOT have insurance
☐ I have Insurance – Name of Carrier: _____
☐ Are you covered under a parent or spouse insurance?
☐ No ☐ Yes

If yes, Insurer Name: _____

Does insurance pay for: Pap tests? ☐ No ☐ Yes
Mammograms? ☐ No ☐ Yes

Do you have a deductible that must be met before diagnostic procedures are covered? ☐ No ☐ Yes

Please provide a copy of the front and back of your insurance card.

Employment Status:
☐ Employed full-time (35+ hours weekly) (EFT)
☐ Employed part-time (EPT)
☐ Not in the labor force (NLF)
☐ Seasonal/Migrant Farm Worker (SMF)
☐ Self-employed (SE)
☐ Temporary Worker (TW)
☐ Unemployed (UNE)

Marital Status:
☐ Never Married (01)
☐ Married (02)
☐ Other: _____

Years of Education Completed:
☐ _____ (EO # of years)
☐ Unknown (E099)

Income determination:

Total income before taxes (if married - total combined income before taxes): $_____ (circle one) per month/year

Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: _____

Office Use Only: Income status for number in household:

At or below 250% of federal poverty level: ☐ Above 250% of federal poverty level: ☐

Are you of Hispanic or Latino origin?
☐ Yes (01) ☐ No (00)

Preferred language for delivery of service:
☐ English (E)
☐ Spanish (S)
☐ Other (O): _____

What races do you consider yourself? Mark ALL that apply.
☐ White
☐ Black or African American
☐ Asian
☐ Chinese ☐ Indian ☐ Japanese
☐ Vietnamese ☐ Korean ☐ Filipino
☐ Other _____
☐ Native Hawaiian/Other Pacific Islanders
☐ American Indian/Alaskan Native

How did you hear about this program?
☐ Poster (PO)
☐ Flier (FL)
☐ Brochure (BR)
☐ Community Navigator (C)
☐ Community Event (CE)
☐ Physician or Health Care Provider (P)
Who: _____ Phone #: _____
☐ Other (OTH), Specify: _____
☐ Newspaper (ME)
☐ Radio (ME)
☐ Television (ME)
☐ Website (Agency/State) (WB)

Barriers:
☐ None ☐ Transportation ☐ Child/family Care ☐ Work schedule
☐ Understanding medical needs ☐ Special needs ☐ Financial
☐ Need Interpreter ☐ Travel Distance ☐ Making appointments
☐ Other: _____

Comments:
_____
_____

What is the best time to schedule your appointments?
(Please mark your choices.)

Preferred Healthcare Provider: _____

Day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time of day: ☐ Early morning ☐ Mid-morning ☐ Early afternoon ☐ Late afternoon

I certify that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature _____ **Date** _____

IBCCP Health Assessment

Name: **Date:**

YES	NO	BREAST HEALTH QUESTIONS
☐	☐	1. Do you perform a monthly breast self-exam?
☐	☐	2. Have you noticed a lump in your breasts?
☐	☐	3. If yes, which breast? Right___ Left____
☐	☐	4. Have you noticed any breast tenderness or pain?
☐	☐	5. If yes, did the breast tenderness or pain increase around the time of your menstrual period?
☐	☐	6. If you answered yes to question #4, which breast? Right _____ Left_____
☐	☐	7. Have you noticed any spontaneous discharge (not from stimulation or squeezing) from your nipples?
☐	☐	8. If yes, which breast? Right _____ Left_____
☐	☐	9. Have you noticed any other symptoms related to your breasts? If yes, explain: _____
☐	☐	10. Have you ever had a breast exam done by a doctor or nurse?
☐	☐	11. If yes, list provider/clinic where breast exam was done: _____
☐	☐	12. If yes, date of last exam (before this current visit): ____/____
☐	☐	13. Have you ever had a mammogram?
☐	☐	14. If yes, list provider/clinic where mammogram was done: _____
☐	☐	15. If yes, date of last two mammograms (before this current visit):___/____, ____/____
☐	☐	16. If unknown was it more than 5 years?
☐	☐	17. Have you ever had breast cancer?
☐	☐	18. Has your mother, sibling (sister/brother) or daughter had breast cancer? If no, go to question 22.
☐	☐	19. If yes, who _____
☐	☐	20. Are they BRCA positive (if known)?
☐	☐	21. If yes, at what age? _____ years old
☐	☐	22. Do you have a breast implant or implants?
☐	☐	23. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
☐	☐	24. If yes, which breast? Right _____ Left_____
☐	☐	25. If yes, list the provider who performed the procedure_____
☐	☐	26. Have you ever had radiation to the chest area?

YES	NO	CERVICAL HEALTH QUESTIONS
☐	☐	27. Have you ever had a Pap test?
☐	☐	28. If yes, list provider where Pap test was done: _____
☐	☐	29. If yes, date of last two Pap tests: (before this current visit): ____/____, ___/____
☐	☐	30. If unknown was it more than 5 years?
☐	☐	31. Were your last Pap test results normal?
☐	☐	32. What was the date of your last menstrual period? ____/____/____
☐	☐	33. Are you pregnant?
☐	☐	34. Have you had a hysterectomy?
☐	☐	35. If yes, was your cervix removed? I do not know_____
☐	☐	36. If you had a hysterectomy, was it due to a past history of cervical disease or cervical cancer?
☐	☐	37. Were you exposed to Diethylstilbestrol (DES)?
☐	☐	38. Is your immune system weakened in any way? (medication, HIV, organ transplant or other health condition)

YES	NO	TOBACCO QUESTIONS
☐	☐	39. Do you smoke cigarettes?
☐	☐	40. If yes, are you ready to quit smoking?
☐	☐	41. If yes, are you interested in being referred to the Illinois Tobacco Quitline?

(Shaded area for IBCCP office use)

42. What date was the referral sent to the Tobacco Quitline? ____/____/____

BARRIER/RISK ASSESSMENT QUESTIONS

Barrier Assessment

43. from Eligibility Determination form

Breast Cancer Risk Assessment

(from Summary Office Visit form)

44. Life time risk_____

45. High risk for breast cancer
- ☐ yes
- ☐ no
- ☐ not assessed/unknown

Cervical Cancer Risk Assessment

46. High risk for cervical cancer
- ☐ yes
- ☐ no
- ☐ not assessed/unknown

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION

I. PROGRAM DESCRIPTION:

The Illinois Breast and Cervical Cancer Program (program) is a cooperative effort between the Illinois Department of Public Health, Office of Women's Health and Family Services, and the U.S. Centers for Disease Control and Prevention (CDC). The program encourages routine breast and cervical cancer screening and provides free screening and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screening is to detect cancer, if present, at an early stage so it can be treated or cured. Screening for breast cancer involves a clinical breast examination and a mammogram (a breast X-ray). Screening for cervical cancer involves a pelvic examination and a Pap test (scraping from the cervix).

II. CONSENT TO PARTICIPATE AND RELEASE OF INFORMATION:

I understand and agree to the following:

- I will provide proof of age and income to determine program eligibility. If I have insurance coverage, I will provide a copy of my insurance card and written verification of covered services. If while enrolled in IBCCP I obtain insurance, I will inform Lead Agency staff.

- I give permission to my health care provider(s), insurance company, hospital, clinic, laboratory and/or mammography facility to provide information concerning my breast and cervical cancer screening, diagnostic examinations and/or treatment status to program staff.

- I understand that the program must obtain certain statistical information for reports, including but not limited to age, income, insurance and any services I am provided through this program. This information may be used by the program and the CDC to learn more about breast and cervical cancer and to ensure the quality of services provided through the program. **My name will not be used in these reports, except as required by law.**

- My health care provider and/or the program staff will try to contact me regarding my test results. I understand that, despite efforts to find me, my health is my own responsibility and I may need to contact my provider for my test results.

- I understand that if the provider orders tests not covered by the program or my insurance that I may be responsible for payment of those IBCCP services as the program cannot pay for some diagnostic exams. A list of allowable services is available upon request.

- If I am diagnosed with a pre-cancerous or cancerous condition of my breasts or cervix, information from my IBCCP file will be released to the Illinois Department of Healthcare and Family Services. This information will be used to determine if I am eligible for state paid health benefits through Medicaid.

- If I am not eligible for Medicaid coverage, the program staff will assist with referral for treatment services through private sources, community based sources, other governmental grants or pro bono from a provider.

- If I am eligible for state paid health benefits through Medicaid, I give my permission for program staff to obtain information about my treatment for breast or cervical cancer. This information will be used to determine my treatment status and my continued enrollment in Medicaid.

- I will receive notification from the program staff to remind me when it is time for me to go back to my medical provider for my annual examination and follow-up testing, if appropriate (This does not apply to insured clients).

- I will notify the program of any change in my address and/or telephone number.

- I will write or call the local program staff to inform them if I no longer wish to be a part of this program. This notification will be recorded in my program records.

- I understand the importance of keeping all appointments made for me so my care can be provided in a timely manner. When it is necessary to cancel or change an appointment, I will notify the agency of this change.

- Missed appointments or repeated "no show" appointments are not acceptable and I can potentially lose my ability to receive IBCCP services if this happens.

III. ACKNOWLEDGMENTS:

- I have received literature and/or education on all of the following: breast health, mammograms, and Pap tests. _____
  (initial here)

- The University of Illinois at Chicago (UIC), an IBCCP partner, conducts an annual survey for the purpose of helping the Department improve the quality of the program so that the Department can provide better services to program participants. UIC will be contacting you about this survey at a future date. We hope that you will participate, but your participation is completely voluntary, and your program eligibility will not be affected if you choose not to participate. Your initials here acknowledge that you have received notification of this voluntary survey. _____
  (initial here)

Client Signature _____ **Date** _____

CONSENT and ACKNOWLEDGEMENT
Receipt of Joint Notice of Privacy Practices

I, _____ (print name of client) do hereby consent to allow DuPage County Health Dept (agency name) and its designated employees and contractors to perform:

- Pelvic and/or breast examinations and screenings and
- Necessary diagnostic follow-up tests

I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the agency dated August 21, 2013.

_____
Signed

_____
Date

FOR STAFF USE ONLY:
I attempted to obtain an Acknowledgement of the Receipt of the Notice of Privacy Practices on behalf of the delegate agency. The agency was unable to obtain the Acknowledgement because:

☐ Client refuses to sign
☐ Other _____ (specify)

_____ Staff member's initials _____ Date

(Staff: Place Acknowledgement in patient's medical record.)

STATE OF ILLINOIS
CORNERSTONE
CORNERSTONE INFORMED CONSENT FORM

Name of Participant:

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (Month/Day/Year) _____ ○ Male ○ Female Participant s ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; Healthy Families Illinois; and Family Health History Questionnaire/Genetics.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Department of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client s name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize DuPage County Health Department (Cornerstone site) to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal; birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program; and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared;

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Department of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photostatic copy/fascimile of this consent will be as valid as the original.

For Child Participant:

OR

For Adult Participant:

_____ Signature of parent/legal guardian/caretaker/Date

_____ Signature of adult participant/Date

Signature of Witness: _____ Date:

Revised April 2011

Appendix E – (d) Cornerstone Informed Consent English (July 2014)