Form 1A

New Hampshire Department of Health and Human Services
Breast and Cervical Cancer Program
ENROLLMENT FORM

TO BE COMPLETED BY ENROLLMENT SITE STAFF

Date of Services: _____/_____/_____

Enrollment Site: _____

Has client ever been enrolled at another BCCP site: ☐Yes / ☐No

If **YES**, location: _____

☐ New enrollment ☐ Re-enrollment

PERSONAL DATA – PLEASE PRINT

Please make sure you complete all information requested on lines 1 through 12.

1. Social Security Number: _____-_____-_____ 2. Date of Birth: _____/_____/_____

3. Name: _____
(Last) (First) (MI) (Maiden name)

4. Hispanic Origin: ☐Yes ☐No

5. Race: ☐White ☐Black or African American ☐Asian ☐Native Hawaiian ☐Other Pacific Islander
☐American Indian or Alaskan Native ☐Unknown

6. Home Address: _____
(Street) (City) (State) (Zip)

7. Mailing Address: _____
(City) (State) (Zip)

8. Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( ) _____

9. County of Residence: _____

10. E-mail Address: _____

Do you have a primary care provider?

11. Name of Primary Care Provider: _____

12. Name of Provider Facility or Practice: _____

TO BE COMPLETED YEARLY BY ALL ENROLLEES

1. How much is your current (**yearly**), **household** income before taxes? $_____

2. Number of people (including yourself) who live in your household: _____

3. Do you have health insurance? ☐Yes ☐No

4. If **No**, was referral made to the Marketplace? ☐Yes ☐No

5. Do you have? ☐Medicare Part A ☐Medicare Part B ☐Medicaid ☐Medicaid Spenddown

6. If you have health insurance or Medicaid Spenddown, what is the amount of your deductible or spenddown?
☐ No deductible ☐ Less than $250 ☐ Greater than $250

How did you hear about this program? ☐ Flier in the mail ☐ Brochure ☐ Doctor or nurse

☐ Newspaper (name) _____ ☐ Friends or relatives ☐ Poster

☐ TV (name) _____ ☐ Radio (name) _____

☐ Other (specify) _____

Form 1B

New Hampshire
Department of Health and Human Services
Breast & Cervical Cancer Program
INFORMED CONSENT

I understand that the purpose of today's exam is to check for breast and cervical cancer. This exam is called a screening. A screening is a search for signs for cancer. This is not a complete physical examination. Today's exam will include a Pap test for cervical cancer, an exam for breast cancer, and I may be sent for a mammogram (an x-ray of the breast).

I understand that these are common medical tests to look for cancer. This screening may detect cancer early but I understand the results of these tests are not always accurate.

I understand that the breast exam, pelvic exam, Pap test and mammogram may be uncomfortable or cause pain. The Pap test may also cause a small amount of bleeding.

I also understand that the mammogram gives a small dose of radiation. It is extremely small, and is highly unlikely to cause harm.

I understand that as a result of today's screening, I may need more tests. If I do need more tests, some may not be paid for by this program. A staff person will help me to find care, if I need it.

I understand that all information about me will be kept private. The medical records of my exam will be kept by this screening site, and I can have them sent to a doctor or health care provider that I choose.

I understand that some information about me and my screening tests will be collected by the New Hampshire Division of Public Health Services, Breast & Cervical Cancer Screening Program and the federal Centers for Disease Control and Prevention in order to learn about the program. Information about a final diagnosis may be included, if I am referred for further tests. I consent to final diagnostic information being released to the screening site where I was screened, the New Hampshire Division of Public Health Services and the federal Centers for Disease Control and Prevention.

I understand that if I also choose to participate in the New Hampshire Mammography Network Project, I agree to allow the New Hampshire Department of Health and Human Services to access information about my care from the data collected as part of that Project.

I understand the New Hampshire Division of Public Health Services will keep my name confidential at all times. When information is shared with the Centers for Disease Control and Prevention my name will be removed.

I give my consent to be screened for breast and cervical cancer.

Name: _____ DOB: _____/_____/_____
Print

Name: _____ DATE _____/_____/_____
Signature

Witness: _____

I request a copy of my screening records be sent to the following doctor:

Name: _____

Address: _____