

The _____ (agency) offers a Breast and Cervical Cancer Control Navigation Program (BCCCNP). This screening program, supported by the Federal Government and the Michigan Department of Health and Human Services, is part of a national plan to reduce the number of women without health insurance who die of breast or cervical cancer.

PURPOSE OF THIS PROGRAM

The purpose of the BCCCNP is to find out if a woman has breast or cervical cancer and, if she has cancer, to assist her in obtaining cancer treatment. Regular screening tests can help find a cancer that may be present when it is still very small and easier to treat.

WHAT THE PROGRAM OFFERS TO YOU

Eligible women who meet the program income guidelines can receive the following services:

BREAST

- Women ages 40-64: breast **screening test (mammogram) and/or follow-up tests** (if needed) for an abnormal finding on a mammogram.
- Women ages 21-39: referred to BCCCNP with an **abnormal clinical breast exam (CBE) and requires breast diagnostic services.**

CERVICAL

- Cervical cancer screening includes a **Pap test and HPV test** (if indicated) according to the client's age.
 - Women ages 21-29: **Pap test ONLY** – HPV testing is unacceptable for this age group and not payable by the BCCCN program.
 - Women ages 30-65: **Pap test and HPV** testing as per BCCCNP medical protocol and cervical screening eligibility guidelines.
 - Women ages 21-64: referred to BCCCNP for cervical **follow-up tests** for an abnormal finding on a cervical screening test.

PROGRAM ELIGIBILITY: (INITIAL _____)

1. Upon enrollment I will be asked if I have health insurance. I will be eligible to receive program services if I meet the other criteria listed in this agreement **AND**:
 - I do not have health insurance **OR**
 - My health insurance DOES NOT cover breast/cervical cancer screening and/or follow-up services **OR**
 - My health insurance has a large deductible that must be paid prior to my receiving services and I am unable to pay the deductible.
2. If I gain insurance after I've enrolled, I must notify the BCCCNP and accurately report this information.
 - If I fail to do this, I understand that I will be responsible for the costs that result from any program services I receive.
3. The BCCCNP is available to women who live in Michigan or live near the border of a neighboring state (Indiana, Ohio, Wisconsin, Minnesota) who plan to receive screening and diagnostic services in Michigan.
 - I must notify the BCCCNP if my residency status changes.
 - If I provide incorrect information about being a Michigan resident or receiving services in Michigan, I will not be eligible for any further services and will be dis-enrolled from the BCCCNP.

NOTIFICATION OF TEST RESULTS AND FOLLOW-UP OF ABNORMAL RESULTS: (INITIAL _____)

1. I will be informed of the results of these screening tests and of any additional follow-up that may be needed.

2. Follow-up tests are offered following an abnormal breast and/or cervical cancer screening result.
3. It is my choice whether or not to follow the recommendations for follow-up of any tests that are abnormal.
4. If any screening test shows something that is abnormal, the BCCCNP agency will help me schedule follow-up exams through providers participating in the program.
5. If I have another provider, s/he will be informed of test results if I provide written approval to release this information.

COST OF PROGRAM SERVICES: (INITIAL _____)

1. The costs of **program-approved** breast and/or cervical cancer screening and follow-up tests are covered by the program.
2. It is possible there may be other tests or procedures recommended to me by my provider.
 - If those recommended tests are not program-approved the BCCCNP cannot pay for those follow-up tests, exams, and/or additional charges.
 - If I am unable to pay, the BCCCNP agency will work with me to help me receive needed services. (i.e. financial assistance and setting up a payment plan if needed)
3. I understand that I should ask the BCCCNP agency what follow-up tests are **program-approved** before completing follow-up tests. I understand that if I have follow-up tests that are not program-approved that I may be responsible for the charges.

IF BREAST OR CERVICAL CANCER IS DIAGNOSED: (INITIAL _____)

1. The BCCCNP does not pay for any treatment services for breast or cervical cancer.
2. If breast or cervical cancer is diagnosed, the BCCCNP agency will determine if I am eligible to participate in a BCCCNP-specific Medicaid program that will provide insurance coverage for my cancer treatment.
 - By initialing above, I understand that once I have completed cancer treatment and/or am no longer eligible for the BCCCNP, this insurance coverage will end.
3. If I am not eligible for treatment coverage through this Medicaid program, the BCCCNP agency will work with me to help me receive treatment. (i.e. financial assistance and setting up a payment plan if needed)

This program has been explained to me and my questions have been answered. Based on my understanding, I have decided to participate in the BCCCNP. I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll.

The BCCCNP agency phone number is (_____/_____-_____).

Signature of Client

Date

Signature of Witness

Date