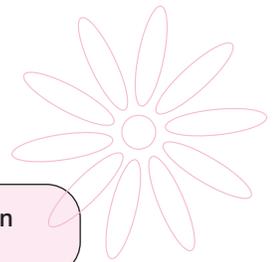


HealthyWoman Project Enrollment Information



The following information will help determine if you are eligible for the Department of Health, HealthyWoman Project. It will also tell us how to make a better Project. Thank you for answering the following questions.

NAME (Last, First, Middle Initial)	MAIDEN NAME	TELEPHONE NO. ()	BIRTH DATE	SOCIAL SECURITY NO.
ADDRESS		COUNTY	STATE	ZIP CODE

1. WHAT IS YOUR TOTAL HOUSEHOLD INCOME EACH MONTH BEFORE TAXES? ▶ \$	2. HOW MANY PEOPLE ARE IN YOUR HOUSEHOLD? INCLUDE YOURSELF ▶
3. DO YOU HAVE ANY CHILDREN UNDER THE AGE OF 21 LIVING WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	4. ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO

5. What type of health insurance do you have? (check one)

- 1. None (uninsured)
- 2. Medical Assistance/ACCESS
- 3. Medicare Part A only
- 4. Private – not HMO – My insurance does not cover screening services provided by the Project.
- 5. Private – not HMO – I am unable to pay the required co-pay or deductible of my insurance.
- 6. Any HMO Coverage
- 7. Medicare Part A and B
- 8. adultBasic

If you checked box #4 or #5, please complete the following:

INSURANCE CARRIER NAME	POLICY NO.	GROUP NO.
IS THE ABOVE PRIVATE INSURANCE OBTAINED THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES – EMPLOYER NAME		EMPLOYER TELEPHONE NO. ()
ADDRESS		

6. If this is your first visit in this program, tell us how you heard of the program. If this is your second year in the program, or if you have been a HealthyWoman client for some time, tell us how you knew to come back. (check one)

- 1. Friend, Relative
- 2. Physician
- 3. Outreach Worker
- 4. Healthcare Provider
- 5. TV/Radio
- 6. Newspaper
- 7. Flyers, Posters, Newsletters
- 8. Reminder
- 9. Church
- 10. Community Event

7. Are you Hispanic or Latina?

- 1. Yes
- 2. No

8. What race do you consider yourself?
(May select more than one)

- 1. White
- 2. Black or African American
- 3. Asian
- 4. Pacific Islander or Native Hawaiian
- 5. American Indian or Alaska Native
- 6. Other

9. What is your marital status?

- 1. Never married
- 2. Married
- 3. Widowed
- 4. Divorced/Separated
- 5. Other

10. What is the highest grade you completed in school? _____

11. Are you a citizen of the United States or an alien in lawful immigration status? Yes No

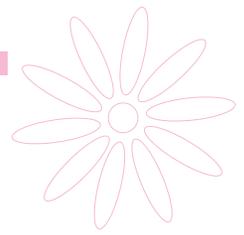
12. Are you a resident of Pennsylvania? Yes No

13. May the Department of Health mail you information about women's health issues? Yes No

Please read and sign the other side of this form.

HealthyWoman Project

A Breast & Cervical Cancer Early Detection Project of the Pennsylvania Department of Health
Funding for this program is provided by the Pennsylvania Department of Health through a cooperative agreement with the Centers for Disease Control and Prevention.



HealthyWoman Project Consent and Enrollment Form Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program Medicaid Eligibility Application – Part A

CHART NUMBER

PROVIDER NAME AND ADDRESS

The Pennsylvania Department of Health (DOH) offers a health project for women called the HealthyWoman Project. This Project offers breast and cervical cancer screening. Screening can find cancer early so it can be treated or cured. The way to screen or test for breast cancer is to have a doctor or nurse examine your breasts and to have a breast X-ray, which is called a mammogram. The way to screen for cervical cancer is to have a pelvic exam and a Pap test. A Pap test is a smear taken from the cervix during the pelvic exam. The HealthyWoman Project pays for screening tests. If you are eligible for this Project, you should not be asked to pay for these tests.

If you have an abnormal screening test result, sometimes more tests are needed. The HealthyWoman provider will help you get the extra tests. The Project can pay for some of the extra tests needed. The provider will tell you if the Project will pay for a test that is recommended before you have the test. If needed, case management services will be offered to you.

If treatment for breast or cervical cancer is needed, the HealthyWoman provider will help you to get treatment. The Project does not pay for treatment. Medicaid may be available to pay for treatment.

HealthyWoman Project Consent for Release of Information

I understand the explanation above about the Pennsylvania Department of Health, HealthyWoman Project for women. I agree to be screened by the HealthyWoman Project. I give permission to any and all of my healthcare providers to provide all personal and medical information to the DOH and its contractors involved in this Project, as necessary, to perform treatment, care, and healthcare operations. This includes information about screening and other test results, treatment, care, and information from this form. I give permission for the DOH to share information with my healthcare provider(s) as needed for treatment, payment, and healthcare operations. I understand that I can revoke this consent at any time, except to the extent that the DOH has already released information based on this consent. I may request further restrictions on the disclosure of my information.

I understand that any information I give to the DOH is confidential. This means the DOH will not disclose or share my information, except for the minimum necessary to administer the Project described above. Statistical reports which result from this Project will not use my name or any other identifying information.

By signing this form, I am stating that I agree to, and understand, the terms of the Project described above. I am also stating that the information I provided on the other side of this form is true. I understand that my participation in this Project is voluntary, and that I can drop out of the Project at any time.

Signature _____

Today's Date _____

Witness Signature _____

Today's Date _____

(Verifies the signature of the Project participant)

Medicaid Breast & Cervical Cancer Prevention & Treatment Program Rights & Responsibilities

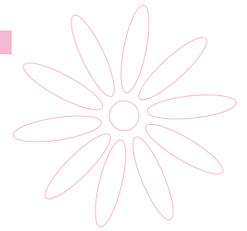
I only wish to apply for screening under the HealthyWoman Project, and do not wish to apply for *the Breast and Cervical Cancer Prevention and Treatment Program* at this time. Please initial:

- I understand that if I need treatment for breast or cervical cancer, the information on this form will be used to see if I am eligible for Medicaid.
- I understand that the information on this form will be kept confidential.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the Medicaid program.
- I understand that I must report any change in my circumstances that may affect my eligibility to the County Assistance Office within one week of the change.
- I understand that I may request a hearing if I do not agree with a decision made on this application.
- I understand that all Medicaid applicants/recipients must provide their Social Security Number, except those applying for treatment for an emergency medical condition. This number may be used to check the information on this application.
- I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when healthcare coverage may be denied or limited for a pre-existing condition. If I enroll in a group plan that allows for a pre-existing condition, I may get credit for the time I received Medicaid.
- I certify that the information on this application is correct under the penalty of perjury.
- I certify that I understand my rights and responsibilities.

Applicant's Signature _____

Date _____

Breast and Cervical Cancer Prevention and Treatment Program



Instructions for completing Form PA 600B

PART I – TO BE COMPLETED BY THE APPLICANT OR APPLICANT'S REPRESENTATIVE

YOUR NAME: Last, First, Middle Initial – Print or type clearly the Last Name, First Name and Middle Initial of the applicant.

DATE OF BIRTH: Enter the eight-digit birth date (mm/dd/yyyy) of the applicant.

SOCIAL SECURITY NUMBER: Enter the nine-digit social security number of the applicant.

PART II – TO BE COMPLETED BY A PROVIDER

DATE OF DIAGNOSIS: Enter either the date of the first positive biopsy/confirmation of diagnosis, or the confirmation of reoccurrence of breast or cervical cancer.

ICD-9 CODE: Check the most appropriate box to indicate the diagnosis, and complete the diagnosis code to individually identify the condition. **Only one box should be checked.** If 196 or 198 is checked, the provider is attesting that the applicant has either breast or cervical cancer, including pre-cancerous conditions of the breast or cervix, as a primary diagnosis. If breast or cervical cancer, including pre-cancerous conditions of the breast or cervix, is not the primary diagnosis, applicant is not eligible for this program.

PROVIDER NAME: Enter the name of the provider who renders medical care to the applicant.

PROVIDER M.A.I.D. NUMBER: If the provider is a Medical Assistance (MA) participating provider, enter the seven-digit Medical Assistance Provider ID number assigned to the designated payee. If the provider is not an MA provider, leave the field blank.

TELEPHONE NUMBER: Enter the telephone number of the office where the applicant is seen.

ADDRESS – STREET, CITY, STATE: Enter the address of the office where the applicant is seen.

PROVIDER AUTHORIZED SIGNATURE AND DATE: Signature of the provider who renders medical care to the applicant and the date the form is completed. **NOTE:** This signature attests to the fact that all information indicated in Part II is complete and accurate.

The provider must fax or mail the application back to the Department of Health's HealthyWoman Project Contractor.

PART III – TO BE COMPLETED BY THE COUNTY ASSISTANCE OFFICE