HWP Intake Site №: _____

pennsylvania
DEPARTMENT OF HEALTH

HealthyWoman Program (HWP) Enrollment Information

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

NAME (Last, First, Middle Initial)	MAIDEN NAME	TELEPHONE NO. ( )	BIRTH DATE
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? ☐ YES ☐ NO		4. ARE YOU PREGNANT? ☐ YES ☐ NO	

5. Were you diagnosed with breast or cervical cancer or pre-cancer prior to filling out this enrollment information? ☐ YES ☐ NO

6. Do you currently have health insurance?
   - ☐ No (Skip to question 7)
   - ☐ Yes, please answer the following questions:

     The type of health insurance I have is:
     - ☐ 1. Medical Assistance/ACCESS
     - ☐ 2. Medicare: ☐ Part A Only ☐ Part B Only ☐ Both Part A & B
     - ☐ 3. Private/Employer Sponsored Plan

     Although I have insurance I need help paying for HWP services because:
     - ☐ My insurance does not cover screening services provided by the HWP.
     - ☐ I am unable to cover the co-pay or deductible required by my insurance.
     - ☐ I have met my benefit limits.

If you checked box #3, Private/Employer Sponsored Plan, please complete the following:

INSURANCE CARRIER NAME	POLICY NO.	GROUP NO.
IS THE ABOVE PRIVATE INSURANCE OBTAINED THROUGH EMPLOYMENT? ☐ YES	☐ NO	
IF YES - EMPLOYER NAME	EMPLOYER TELEPHONE NO. ( )	
ADDRESS		

7. Is this your first visit in this program? ☐ YES ☐ NO Tell us how you heard of the program. Is this your second year in the program or have you been a HWP client for some time? ☐ YES ☐ NO Tell us how you knew to come back. (check one)
   - ☐ Friend, Relative
   - ☐ Physician
   - ☐ Outreach Worker
   - ☐ Healthcare Provider (other than a physician)
   - ☐ TV/Radio
   - ☐ Newspaper
   - ☐ Flyers, Posters, Newsletters
   - ☐ Reminder/Invitation from HWP
   - ☐ Church
   - ☐ Community Event
   - ☐ Other, please specify _____

8. Are you Hispanic or Latina?
   - ☐ Yes (1)
   - ☐ No (2)

9. What race do you consider yourself? (May select more than one)
   - ☐ White (1)
   - ☐ Black or African American (2)
   - ☐ Asian (3)
   - ☐ Pacific Islander or Native Hawaiian (4)
   - ☐ American Indian or Alaska Native (5)
   - ☐ Other (6)

10. What is your marital status?
   - ☐ Never married (1)
   - ☐ Married (2)
   - ☐ Widowed (3)
   - ☐ Divorced/Separated (4)
   - ☐ Other (5)

11. What is the highest grade you completed in school?

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

13. Are you a resident of Pennsylvania? ☐ Yes ☐ No

14. 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 Program
A Breast & Cervical Cancer Early Detection Program 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 Program Consent and Enrollment Form
Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program
Medicaid Eligibility Application - Part A

CLIENT NAME	CHART NUMBER
PROVIDER NAME AND ADDRESS	

The Pennsylvania Department of Health (DOH) offers a health program for women called the HealthyWoman Program (HWP). This Program 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 HWP pays for screening tests. If you are eligible for this Program, 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 Program can pay for some of the extra tests needed. The provider will tell you if the Program 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 Program does not pay for treatment. Medicaid may be available to pay for treatment.

HealthyWoman Program Consent for Release of Information

I understand the explanation above about the Pennsylvania Department of Health, HWP for women. I agree to be screened by the HWP. 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 Program, 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 I have been provided access to a PA Department of Health Notice of Privacy (Notice) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the most current Notice is available at this clinic site for my review or one may be obtained by contacting the Department of Health, HealthyWoman and WISEWOMAN Program at 625 Forster St, Harrisburg, PA 17120 or on the Web site at http://www.health.state.pa.us/hipaanotice.

Initial here: _____

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 Program described above. Statistical reports which result from this Program 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 Program 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 Program is voluntary, and that I can drop out of the Program at any time.

Signature _____ Today's Date _____

Witness Signature _____ Today's Date _____
(Verifies the signature of the Program participant)

Medicaid Breast & Cervical Cancer Prevention & Treatment (BCCPT) Program

I understand that my diagnosis and other eligibility factors provide me the option to enroll in the Medicaid BCCPT Program.
I decline to enroll in the BCCPT Program at this time. Please initial and date: _____ _____

Please review and complete the following section only if you agree to proceed with enrollment in the Medicaid BCCPT Program.

Medicaid BCCPT Program Rights and Responsibilities

- 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 _____

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program Medicaid Eligibility Application – Part B

Instructions for completing Form PA 600B – Part B

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

The Applicant or Applicant's representative should:

1. Print clearly or type the information in the spaces provided on the other side of this form.

2. Sign and date this form.

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 MPI/NPI NUMBER: If the provider is a Medical Assistance (MA) participating provider, enter the 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 Program Provider.

HWP Intake Site _____ Fax Number _____

HWP Intake Site Number _____

PART III – TO BE COMPLETED BY THE COUNTY ASSISTANCE OFFICE

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

APPLICANT'S NAME (Last, First, Middle Initial)	BIRTH DATE	SOCIAL SECURITY NUMBER
BIRTHPLACE (State, County, City)	NAME ON BIRTH CERTIFICATE (Last, First, Middle)	MOTHER'S MAIDEN NAME (Last, First, Middle)
APPLICANT'S SIGNATURE	DATE	DRIVER'S LICENSE OR ID (State/Number)

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register will not affect the amount of assistance that you will be provided by this agency.
If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__	☐ Sent to voter registration __/__/__	☐ Mailed to Client __/__/__
☐ Declined, not interested __/__/__	☐ Not a U.S. citizen __/__/__	☐ Declined, already registered __/__/__

PART II. TO BE COMPLETED BY A PROVIDER

DATE OF FIRST BIOPSY/ CONFIRMATORY DIAGNOSIS ▶ | OR | DATE OF CONFIRMATION OF REOCCURRENCE OF BREAST OR CERVICAL CANCER ▶

ICD.9 CODE	CLINICAL DESCRIPTOR	INITIAL ELIGIBILITY TIMEFRAME
BREAST CANCER		
☐ **174.____**	**Malignant Neoplasm of Female Breast, Primary** (Includes: **174.0** - Nipple and areola; **174.1** - Central Portion; **174.2** - Upper-inner quadrant; **174.3** - Lower-inner quadrant; **174.4** - Upper-outer quadrant; **174.5** - Lower-outer quadrant; **174.6** - Axillary tail; **174.8** - Other specified sites of female breast; **174.9** - breast, unspecified.	**12 month**
☐ **196.____**	**Secondary and Specified/Unspecified Malignant Neoplasm of Lymph Nodes (with Breast Primary)** (Includes: **196.1** - Intrathoracic lymph nodes (bronchopulmonary, mediastinal, intercostal, tracheobronchial); **196.3** - Lymph nodes of axilla and upper limb (brachial, infraclavicular, epitrochlear, pectoral); **196.8** - Lymph nodes of multiple sites	**12 month**
☐ **198.____**	**Secondary Malignant Neoplasm of Other Site (with Breast Primary)** (Includes: **198.2** - Skin (skin of breast); **198.3** - Brain and spinal cord; **198.5** - Bone and bone marrow; **198.81** - Other specified sites (breast, excludes skin of breast); **198.89** - Other (with breast CA primary)	**12 month**
☐ **233.**	**Carcinoma in Situ, Breast**	**6 month**
☐ **233.0**	**Breast**	
CERVICAL CANCER		
☐ **180.____**	**Malignant Neoplasm, Cervix uteri** (Includes: **180.0 -** Endocervix (Cervical canal NOS, Endovervical gland, endocervical canal); **180.1** - Exocervix; **180.8** - Other specified sites of cervix (Cervical stump, squamocolumnar junction of cervix, malignant neoplasm of contiguous or overlapping sites of cervix uteri whose point of origin cannot be determined); **180.9** - Cervix uteri; unspecified	**6 month**
☐ **196.____**	**Secondary and Specified/Unspecified Malignant Neoplasm of Lymph Nodes (with Cervix Primary)** (Includes: **196.2** - Intra-abdominal lumph nodes (Intestinal, retroperitoneal, mesenteric), **196.5** - Lymph nodes of inguinal region and lower limb (Femoral, popliteal; groin, Tibial), **196.6** - Intrapelvic lymph nodes (Hypogastric, obturator, iliac, parametrial), **196.8** - Lymph nodes of multiple sites.	**6 month**
☐ **198.____**	**Secondary Malignant Neoplasm of Other Site (with Cervix Primary)** (Includes: **198.1** - Other urinary organs; **198.3** - Brain and spinal cord; **198.5** - Bone and bone marrow; **198.6** - Ovary; **198.82** - Genital organs; **198.89** - Other (with cervix CA primary)	**12 month**
PRE-CANCEROUS CONDITIONS		
☐ **233.1**	**Carcinoma in Situ Cervix** (Cervical Intra-epithelial Neoplasia Grade III only)	**3 month**
☐ **238.____**	**Neoplasm of Uncertain Behavior** (Includes: **238.2** - Skin (excludes: anus, skin of genital organs, vermillion border of lip); **238.3** - Breast (excludes skin of breast)	**3 month**
☐ **622.1**	**Dysplasia of Cervix** (Cervical Intra-epithelial Neoplasia Grade II only)	**3 month**

PROVIDER NAME (Confirming diagnosis)	PROVIDER MPI/NPI NUMBER	TELEPHONE NUMBER ( )
ADDRESS	STATE	ZIP CODE

PROVIDER AUTHORIZED SIGNATURE _____ DATE _____

PROVIDER: Please fax ( ) or mail this application back to the Department of Health's HealthyWoman Program Screening Contractor.

PART III. TO BE COMPLETED BY COUNTY ASSISTANCE OFFICE

1. ☐ APPLICANT IS ELIGIBLE FOR ONGOING MEDICAID - BEGINNING ▶ Month | Day | Year

2. ☐ APPLICANT IS NOT ELIGIBLE FOR ONGOING MEDICAID

REASON FOR REJECTION: ☐ NO DOCUMENTATION OF ALIEN STATUS

☐ OTHER:

COUNTY NUMBER

RECORD NUMBER

CATEGORY LINE NO.

CAO WORKER'S SIGNATURE

DATE