BEAUFORT COUNTY PUBLIC HEALTH NORTH CAROLINA

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# Beaufort County Public Health Department

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## NC BREAST AND CERVICAL CANCER CONTROL PROGRAM
## Consent for Services/Release of Medical Information

The NC Breast and Cervical Cancer Control Program (NC BCCCP) provides screening tests and/or limited diagnostic testing for breast and cervical cancer to eligible women ages 21-64. NC BCCCP may also provide screening and/or limited diagnostic testing **in special circumstances to women who present with symptoms under the age of 40** who meet eligibility criteria and whose diagnostic services are not otherwise covered through another program (for example, Title X Family Planning). In addition, NC BCCCP provides Patient Navigation-Only services for women who are diagnosed with breast or cervical cancer or breast or cervical pre-cancer outside of NC BCCCP. Patient Navigation- Only services are provided to assist with an application for Breast and Cervical Cancer Medicaid (BCCM).

_____ I consent for NC BCCCP Screening/Diagnostic Services
(patient initials)

_____ I consent for Patient Navigation- Only Services
(patient initials)

I understand a screening may include or more of these tests:

- Clinical Breast Exam.
- Pelvic exam with cervical cytology (ages 21-64 every three (3) years; of note, women ages 30 years and above may be screened every three (3) years with cervical cytology alone, every five (5) years with hrHPV testing alone, or every five (5) years with cervical cytology/hrHPV co-testing).
- Screening mammogram every 1-2 years after age 50 (or after age 40 if state funds are available).

I understand the program can only provide and pay for tests that are approved by the program. I understand that all results of the screening tests will be explained to me. If any test results are abnormal, I will be referred to another provider for more testing or treatment. All information will be kept private; only my medical provider or nurse and the NC BCCCP staff can see it.

If further tests or surgeries are needed which are not covered by NC BCCCP, I understand I am responsible eto work out a payment plan with my medical provider. I am responsible for keeping any appointments made for me. If I choose not to follow the program recommendations, treatment plan or referrals to other providers, I accept full responsibility for the consequences of my decision.

I consent to planning of services to diagnose and treat problems found through NC BCCCP screening.

I authorize **Beaufort County Health Department** to send NC BCCCP test results to the provider of my choice and to NC BCCCP. I also authorize my physician or medical facility to release the diagnosis or findings pertaining to any breast and/or cervical cancer screening and/or diagnostic procedures to the **Beaufort County Health Department.** The purpose of sending and receiving this information is to coordinate my care and provide information for statistical purposes.

DATE:_____ Signature:_____

Interpreter:_____ Witness: _____

**Beaufort County Health Department**
**Breast and Cervical Cancer Control Program**
**Client Registration and Financial Information**

**First Name:** _____ **Middle:** _____ **Last Name:** _____

**Maiden or Other Name Used:** _____

**Date of Birth:** _____ **Social Security #:** _____

**Mailing Address (including City, State, and Zip Code):** **County:**_____

_____

**Home Phone #:** _____ **Work Phone #:** _____ **Cell Phone #:** _____

**Can we contact you by mail?** ☐ Yes ☐ No - If no, can we send a plain envelope with no return address? ☐ Yes ☐ No

**Can we contact you by phone?** ☐ Yes ☐ No **Primary Language:** ☐ English ☐ Spanish ☐ Other:_____

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

**Race:** ☐ White ☐ Hispanic ☐ Native American ☐ Asian ☐ African American

**Do you have insurance, Medicaid or Medicare?** ☐ Yes ☐ No

Please list family members who live in your household and their income. To be eligible, gross household income must be 250% of the Federal Poverty Level or less.

| Name | Relation to Patient | Income Earned |
|---|---|---|
| | **Self** | |
| | | |
| | | |
| | | |
| | | |

| Family Size | Total Income |
|---|---|
| | |

***My signature below indicates to the best of my knowledge this income is true and correct.***

**Client Signature:** _____ **Date:** _____

**Witness:** _____ **Date:** _____

# Beaufort County Health Department
# Breast and Cervical Cancer Control Program
## Needs Assessment

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all your needs, but we will try and help as much as we can.

| | Yes | No |
|---|---|---|
| **Food** | | |
| 1. Within the past 12 months, did you worry that your food would run out before you got money to buy more? | | |
| 2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more? | | |
| **Housing/ Utilities** | | |
| 3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)? | | |
| 4. Are you worried about losing your housing? | | |
| 5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed? | | |
| **Transportation** | | |
| 6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living? | | |
| **Interpersonal Safety** | | |
| 7. Do you feel physically or emotionally unsafe where you currently live? | | |
| 8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone? | | |
| 9. Within the past 12 months, have you been humiliated or emotionally abused by anyone? | | |
| **Optional: Immediate Need** | | |
| 10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today. | | |
| 11. Would you like help with any of the needs that you have identified? | | |

Notes:

Signature_____ Date_____

Reviewed by: _____