Washington State Department of Health

Public Health
Seattle & King County

Breast Cervical & Colon Health Program
401 5th Ave #1110, Seattle WA 98104
T 206-263-8176 F 206-296-0208

BREAST & CERVICAL CANCER TREATMENT PROGRAM ELIGIBILITY, RELEASE AND CONSENT FORM

Please Print ***FOR OFFICE USE ONLY***

Last Name	**First Name**	**MI**	**BCCHP Prime Contractor**	**Diagnosis Date**
Date of Birth	**Social Security Number**		**BCCHP Case Manager Name:**	
Address			**BCCHP Case Manager Phone:** **Fax:**	
City	**State**	**Zip Code**	**BCCHP ID #**	**Medicaid ID #**
Telephone Numbers: **OK to leave a message?** ☐ **Yes** ☐ **No** **Home:** **Cell:** **Alternate:**			**Clinic Chart #**	**Clinic Name**

What is your household income before taxes? **$ _____** **per ☐ Week ☐ Month ☐ Year**

Number of people living in household being supported on household income: **_____**

Do you have health insurance? ☐ **Yes** ☐ **No** **If Yes, Company:_____** **Policy #_____**

Do you have unpaid medical bills from this breast or cervical cancer diagnosis? ☐ **Yes** ☐ **No**

If Yes: # of months before your diagnosis date that the testing began and was not covered by BCCHP or insurance**:** ☐ **1** ☐ **2** ☐ **3**

Are you a Washington state resident? ☐ **Yes** ☐ **No**

Are you a U.S. citizen? ☐ **Yes** ☐ **No**

Were you born in a US Territory? ☐ **Yes** ☐ **No** **Where?_____**

Are you a U.S. Permanent Resident? ☐ **Yes** ☐ **No** ☐ **Not Applicable**

Permanent Resident since: (date on P.R. card) _____ **(It is only necessary to copy PR card once for initial app, not for renewals)**

Primary Language? (check all that apply, circle the one you prefer) ☐ **English** ☐ **Spanish**

☐ **Vietnamese** ☐ **Chinese** ☐ **Korean** ☐ **Cambodian** ☐ **Russian** ☐ **Other (specify: _____)**

Do you need an interpreter? ☐ **Yes** ☐ **No**

I understand that:

- I am being referred to the Washington State Health Care Authority (HCA) Apple Health Medicaid Program for medical coverage for breast or cervical cancer treatment.
- This information will not be shared with the U.S. Citizenship and Immigration Services (USCIS).
- I give the Breast Cervical & Colon Health Program (BCCHP) release of medical records for documentation of treatment.
- I give the State of Washington rights to any medical support benefits and to any third party payments for health care.

I have read and understand the above information. I declare, under penalty of perjury, the information I have provided is true, correct, and complete to the best of my knowledge.

Client Signature: _____Date:_____

Case Manager Signature: _____Date:_____

FOR BCCHP CASE MANAGER USE:

Initial eligibility screening date: _____ Re-verification date**:** _____ Remains eligible: ☐ **Yes** ☐ **No** (If no, explain in notes)

Requested coverage start date: _____ **AEM / ERSO:** ☐ **Yes** ☐ **No** **BCCHP** Consent form current: ☐ **Yes** ☐ **No**

*Case Management Notes**:***

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY call 711).

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Authorization#: _____ BCCHP#: _____

Breast, Cervical and Colon Health Program Consent

PROGRAM DESCRIPTION

The **Breast, Cervical and Colon Health Program (BCCHP)** is a joint effort between health providers, the Washington State Department of Health (DOH), and the Centers for Disease Control and Prevention (CDC) to support screening for breast, cervical and colon cancer. The purpose of screening is to detect cancer in its earliest stage so that it can be prevented or treated. Screening for breast cancer includes a breast exam and breast x-ray called a mammogram. Screening for cervical cancer includes a pelvic exam and taking a sample of cells from the cervix (opening of the uterus/womb) called a Pap and HPV test. Screening for colon health includes a test for blood in the stool called FOBT or FIT that you take-home and return to your clinic/provider. You may need a colonoscopy or sigmoidoscopy.

CONSENT FOR RELEASE OF INFORMATION

I give consent to any and all of my medical care providers, clinics, hospitals, health insurance plans, and the BCCHP to provide each other with information about my health care, cervical tests, breast exams, mammograms, stool tests (FOBT/FIT), colonoscopy, sigmoidoscopy and any related medical care I receive through the BCCHP. I understand that this consent form expires 12 months after the date I sign this form. I must re-enroll after 12 months to continue services.

Any information released to the BCCHP will remain confidential. The information will be available to me, to the employees involved in my BCCHP services, the Health Care Authority (for the Breast and Cervical Cancer Treatment Program (BCCTP) if applicable), and to the Department of Health (the funding source of the BCCHP). The information will be used to meet the purposes of the BCCHP as described above. Published reports that result from the BCCHP will not identify any clients by name.

I understand that being in this program is voluntary and that I may drop out of the BCCHP and withdraw my consent to release information at any time. I understand that if I am found to have breast and/or cervical cancer, I may be eligible to receive treatment through the Apple Health BCCTP. The BCCHP staff would then assist me in enrolling. As part of the Case Management services I receive, I understand I will be required to give my consent for treatment and provide other information as needed. If I am screened and am found to have colon cancer, the BCCHP staff will assist me in finding treatment resources regardless of my ability to pay.

If I falsify any information used to determine my eligibility, I understand that I am liable for the charges.

Sign Your Name Here Date	Witness: Health Facility Date
Print Your Name Here	Interpreter (if used) Date

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Breast Cancer Treatment Program Tracking Form

Please Print Clearly

Client Last Name	Client First Name	MI	Social Security Number:	Date of Birth:

BCCHP Prime Contractor:	BCCHP ID #	Provider One #:

Primary Care Provider Name:	Enrolling Clinic Name :	Clinic Chart #:

Breast Diagnosis Date: _____

1. ☐ **Unspecified Benign Dysplasia* -** Dx code:**N60.99**
   (* Unspecified Benign Dysplasia is not a qualifying diagnosis *for AEM/ERSO)*
2. ☐ **Carcinoma in situ (CIS) of breast – Right Side (Choose one from the options below)**
   - ☐ **Lobular CIS, right -** Dx code: **D05.01**
   - ☐ **Intraductal CIS, right -** Dx code: **D05.11**
   - ☐ **Other CIS, Specified right -** Dx code: **D05.81**
   - ☐ **Other CIS, Unspecified right -** Dx code:**D05.91**
3. ☐ **Carcinoma in situ (CIS) of breast – Left Side (Choose one from the options below)**
   - ☐ **Lobular CIS, left -** Dx code: **D05.02**
   - ☐ **Intraductal CIS, left-** Dx code: **D05.12**
   - ☐ **Other CIS, Specified left -** Dx code: **D05.82**
   - ☐ **Other CIS, Unspecified left-** Dx code: **D05.92**
4. ☐ **Malignant Neoplasm – Right Side -** Dx code: **C50.911**
5. ☐ **Malignant Neoplasm – Left Side -** Dx code: **C50.912**
6. ☐ **Metastatic disease** **Site of Metastatic Disease**_____

Current Treatment Plan - Breast

☐ **Office Visit to initiate staging and treatment plan Appointment Date:**_____
☐ **Chemotherapy Start Date:**_____ **End Date:**_____
☐ **Radiation Start Date:**_____ **End Date:** _____
☐ **Surgery:** ☐ **Excision** ☐ **Lumpectomy Date of Surgery:**_____
☐ **Surgery: Mastectomy:** ☐ **Modified** ☐ **Radical Date of Surgery:** _____
☐ **Surgery: Reconstruction* Date of Surgery:** _____ *(* reconstruction not available for AEM/ERSO)*
☐ **Endocrine therapy: Prescription Name :** _____
Start date of Endocrine therapy: _____ **Proposed end date:** _____

Treatment Status: _____ **Current Tx start date:** _____ **Tx complete date:** _____

Tx suspended date: _____ ☐ **Declines/refuses Tx** ☐ **Lost to follow-up** (left area, missed appts)

Treatment Comments / Follow-up Plan:

Provider (signature): _____**Date:**_____ **NPI #** _____

Provider Name (print): _____ **Phone:**_____ **Medicaid #** _____

FOR BCCHP CASE MANAGER USE:

☐ **AEM/ERSO eligible only**
☐ **New enrollment**
☐ **Renewal – client continues active treatment**
☐ **Other:**_____

BCCHP Case Manager:
Name & Email:
Phone: **Fax:**

☐ **No longer eligible for BCCTP (S30):**
- ☐ **All cancer treatment completed**
- ☐ **Now eligible for Apple Health**
- ☐ **Now eligible for Medicare**
- ☐ **Has other Creditable Insurance**
- ☐ **Moving out of state to:** _____
- ☐ **Renewal forms not completed**

Case Manager Signature: _____ **Date:** _____

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Cervical Cancer Treatment Program Tracking Form

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Client Last Name	Client First Name	MI	Social Security Number:	Date of Birth:

BCCHP Prime Contractor:	BCCHP ID #	Provider One #:
Primary Care Provider Name:	Enrolling Clinic Name :	Clinic Chart #:

Cervical Diagnosis Date: _____

1. ☐ **CIN 2/Moderate Dysplasia -** Dx code: **N87.1**
   (*CIN 2 is *not a qualifying diagnosis for AEM/ERSO)*
2. ☐ **CIN 2-3/severe dysplasia** (Pleases choose one of the diagnostic codes from CIN 3 below)
3. ☐ **CIN 3/severe dysplasia/carcinoma in situ (CIS), stage 0 (choose one from options below)**
   - ☐ **CIS, endocervix -** Dx code: **D06.0**
   - ☐ **CIS, exocervix -** Dx code: **D06.1**
   - ☐ **CIS, other part of cervix -** Dx code: **D06.7**
   - ☐ **CIS, unspecified -** Dx code:**D06.9**
4. ☐ **Adenocarcinoma in situ (AIS) (choose one from option below)**
   - ☐ **AIS, endocervix -** Dx code: **D06.0**
   - ☐ **AIS, exocervix -** Dx code: **D06.1**
   - ☐ **AIS, other part of cervix -** Dx code: **D06.7**
   - ☐ **AIS, unspecified -** Dx code: **D06.9**
5. ☐ **Malignant Neoplasm -** Dx code: **C539.9**
6. ☐ **Metastatic disease** **Site of Metastatic Disease:** _____

Current Treatment Plan - Cervical

☐ **LEEP** **Start Date:**_____ **End Date:**_____
☐ **Cone** **Start Date:**_____ **End Date:**_____
☐ **Cryo** **Start Date:**_____ **End Date:**_____
☐ **Hysterectomy Start Date:**_____ **End Date:**_____
☐ **Chemotherapy Start Date:**_____ **End Date:**_____
☐ **Radiation Start Date:** _____ **End Date:**_____

Treatment Status: **Current Tx start date:** _____ **Tx complete date:** _____

Tx suspended date: _____ ☐ **Declined/refused Tx** ☐ **Lost to follow-up** (left area, missed appts)

Treatment Comments / Follow-up Plan:

Provider (signature): _____**Date:**_____ **NPI #** _____

Provider Name (print): _____ **Phone:**_____ **Medicaid #** __

FOR BCCHP CASE MANAGER USE:

☐ **AEM/ERSO eligible only**
☐ **New enrollment**
☐ **Renewal – client continues active treatment**
☐ **Other:**_____

BCCHP Case Manager:
Name & Email:
Phone: **Fax:**

☐ **No longer eligible for BCCTP (S30):**
- ☐ **All cancer treatment completed**
- ☐ **Now eligible for Apple Health**
- ☐ **Now eligible for Medicare**
- ☐ **Has other Creditable Insurance**
- ☐ **Moving out of state to:** _____
- ☐ **Renewal paperwork not returned**

Case Manager Signature: _____ **Date:** _____