Enrollment / Re-enrollment Form

For clinic use only
BCCP ID#: ______________________
Enrolling Site: ______________________

Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth: ____/____/____	☐ Female ☐ Male	SSN: (Optional)	Maiden Name:
Street:	Apartment #:	Homeless? ☐ Yes
City:	State:	ZIP:	County:
Phone 1:	Phone 2:	Email:

Eligibility Information

Do you have health insurance? ☐ Yes, OHP ☐ Yes, Medicare-Part B ☐ Yes, other health insurance ☐ No

If yes, are any of the following TRUE?

- ☐ My health insurance plan does not cover preventive screenings like mammograms and/or Pap tests.
- ☐ I have an unmet deductible of $500 or more.

What is your gross monthly household income? (This is total income before taxes for all household members). $ ____________

How many people live in your household (including yourself)? ____________

Demographic Information (We are collecting this information so that we know who our program is reaching.)

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Language preference: (if other than English)

Race: (check all that apply) ☐ White ☐ Black or African-American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐ Asian If Asian: ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other Asian:____________

Slavic or Eastern European descent? (optional) ☐ Yes ☐ No

Disability: (check all that apply; optional) ☐ Physical/mobility ☐ Hearing ☐ Vision ☐ Intellectual/cognitive ☐ Mental health/psychiatric ☐ Other developmental (ex: autistic) ☐ Other: ____________

Sexual Orientation: (check ONE; optional) ☐ Lesbian or gay ☐ Bisexual ☐ Heterosexual/Straight ☐ Other

Where did you hear about this program? (check all that apply) ☐ 1-877 toll-free number ☐ A doctor or nurse ☐ Susan G. Komen for the Cure ☐ Friend or family member ☐ Newspaper ☐ Internet ☐ Cancer Information Service (CIS) ☐ Other:____________

Alternate Contact Information (In case we cannot reach you.)

Name:	Relationship to You:	
Street:		Apartment #:
City:	State:	ZIP:
Phone:		

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Client Consent

I voluntarily consent to be seen in the Oregon Breast and Cervical Cancer (OBCC) Program. If follow-up is needed, I agree to case management services.

I understand that screening for breast cancer involves a breast examination and a mammogram.
I understand that screening for cervical cancer involves a pelvic examination and a Pap test.

I further understand that:

- I understand that the personal information I give (ex: race, disability status) is not used to determine eligibility but to help make sure all Oregonians can receive services.
- These exams/tests do not detect all breast or cervical cancer.
- I should receive regular health care from my health care provider for annual check-ups and follow-up of abnormal results.
- If my breast or cervical tests are abnormal, I may need more testing until a diagnosis is made. Most or all of these tests will be paid for by the OBCC Program.
- The OBCC Program does not cover services for other health conditions and some diagnostic services.
- If I need more tests, a case manager from OBCC Program may contact me to arrange for the services I need.

In order to receive services in the OBCC Program, I agree to:

- Provide true and accurate information.
- Give my consent to release the results of my exams and diagnostic tests to providers in the OBCC Program, the OBCC Program, and funders of the Program.

My rights include:

- My medical information is confidential and will not be released to anyone outside OBCC Program-contracted providers, the OBCC Program, and its funders. Any published report will not identify me by name.
- My participation in the OBCC Program is voluntary and I may withdraw from the OBCC Program at any time. I may also revoke my consent to release my information at any time at the clinic site where I obtained services. I understand that by revoking consent to release my information I will no longer be able to receive OBCC Program services.

Patient's signature:	Date:
Witness/interpreter:	Date:

Funding for this program generously provided by the Centers for Disease Control & Prevention and Oregon & SW Washington Affiliate of Susan G. Komen for the Cure.

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Does patient meet ALL of the following eligibility criteria?

- Currently an Oregon resident or intends to reside in Oregon
- Under 250% FPL (Federal Poverty Level)
- No health insurance OR
  health insurance does not cover breast and cervical procedures OR
  health insurance has a high deductible

For women under 40 or for men, any of the following breast symptoms MUST be present:

- Persistent palpable/suspicious mass
- Bloody/serous nipple discharge
- Nipple/areolar scaliness
- Skin dimpling or retraction
- Ulceration
- Inflammation of the skin