MDHHS-6198, BREAST AND CERVICAL CANCER CONTROL NAVIGATION PROGRAM – PROGRAM PARTICIPATION CONSENT

Michigan Department of Health and Human Services (MDHHS)
(Revised 8-25)

The HDNW (agency) offers a Breast and Cervical Cancer Control Navigation Program (BC3NP). The BC3NP is a federally funded program administered by the Michigan Department of Health and Human Services. The BC3NP helps people in Michigan without health insurance receive breast and cervical cancer screening services.

PURPOSE OF THIS PROGRAM

The purpose of the BC3NP is to find out if a client has breast or cervical cancer and, if they have either cancer, to assist in obtaining cancer treatment. Regular screening tests can help find cancer early when it is easier to treat.

WHAT THE PROGRAM OFFERS TO YOU

Eligible individuals ages 21-64, who meet the program income and eligibility guidelines for services, may receive breast cancer screening (mammograms for those aged 40 and older), cervical cancer screening (Pap tests only for clients aged 21 -64; Pap tests and/or Human Papillomavirus (HPV) tests for clients aged 30-64), and follow-up tests for an abnormal breast or cervical cancer test result.

PROGRAM ELIGIBILITY (Initials _____)

1. Upon enrollment I will be asked if I have health insurance. I will be eligible to receive program services If I meet the other criteria listed in this agreement **AND**:
   - I do not have health insurance **OR**
   - My health insurance has a large deductible that must be paid prior to my receiving services, and I am unable to pay that deductible **OR**
   - My health insurance **DOES NOT** cover breast/cervical cancer screening/follow-up services.
2. If I gain insurance after I've enrolled, I must notify the BC3NP program and accurately report this information.
   - If I fail to do this, I understand that I will be responsible for the costs that result from any program services I receive.

COST OF PROGRAM SERVICES

1. BC3NP covers the costs of **program-approved** cancer screening and follow-up tests.
2. It is possible there may be other tests or procedures recommended to me by my provider.
3. If those recommendations are not program-approved, the BC3NP cannot pay the associated charges.
4. If I am unable to pay, the BC3NP agency will work with me to help me receive needed services. (i.e., financial assistance and setting up a payment plan if needed).
5. I understand that I should ask the BC3NP agency what follow-up tests are **program-approved** before completing follow-up tests**. I understand that if I have follow-up tests that are not program approved that I may be responsible for the charges.**

NOTIFICATION OF TEST RESULTS

1. I will be informed of the results of these screening tests and of any additional follow-up that may be needed.
2. It is my choice whether [or not] to follow the recommendations for follow-up of any tests that are abnormal.

3. If any screening test shows something that is abnormal, the BC3NP agency will help me schedule follow-up exams through providers participating in the program.
4. If I have another provider, they will be informed of test results.

IF BREAST OR CERVICAL CANCER IS DIAGNOSED

1. The BC3NP does not pay for any **treatment** services for breast or cervical cancer.
2. If breast or cervical cancer is diagnosed, the BC3NP agency will determine if I am eligible to participate in a BC3NP-specific Medicaid program that will provide insurance coverage for my cancer treatment.
3. I understand that once I have completed cancer treatment and/or am no longer eligible for the BC3NP, **this insurance coverage will end**.
4. If I am not eligible for treatment coverage through this Medicaid program, the BC3NP agency will work with me to help me receive treatment (i.e., financial assistance and setting up a payment plan if needed).

This program has been explained to me and my questions have been answered. Based on my understanding, I have decided to participate in the BC3NP program. I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this program, I wish to enroll.

Signature of Client →	Date
Signature of Witness →	Date

RELEASE OF INFORMATION

I Understand That:

- Any personal information obtained about me will be kept private and confidential.
- By signing this form, I authorize you to release confidential health information as described below.
- The following health information may be released: my name, my contact information, my insurance status, results of prior breast and/or cervical test results and BC3NP services needed.
- The purpose of this release of information is to facilitate possible enrollment into the BC3NP and related referrals.
- I have the right to revoke this authorization, in writing, at any time.

I give permission to:

- Agencies performing my screening or follow-up testing (if needed) to release information regarding my test results to the BC3NP agency providing my care.
- Provide information about my medical history and test results to providers I may be referred to for follow-up care.

CONTENTS OF THIS FORM REMAIN IN EFFECT ONE YEAR FROM DATE SIGNED

Signature of Client →	Date
Signature of Witness →	Date