Prairie State Women's Health

11191 Illinois Route 185
Hillsboro, IL 62049
Ph. 217-532-2001 * Fax 217-532-6676

Dear _____,

First, we would like to thank you for participating in the Illinois Breast and Cervical Cancer Program. This program is a successful endeavor, partnering Prairie State Women's Health, the State of Illinois and the federal government for the betterment of women throughout the State. We are providing you with the paperwork necessary to enroll in this program for this year. These forms must be completed each year in order to maintain your eligibility.

When completing these forms, please check both sides of each form, as some are two-sided. Complete all the highlighted areas on each form and sign where necessary. You will also need to include a signed and dated copy of your proof of income. (A copy of your tax return or one month of paycheck stubs.) Also, a signed and dated copy of your driver's license or a photo ID must be included as proof of your identity and age. Please call (217) 532-2001 or 1-800-331-1689 and ask for Prairie State Women's Health Clerical Department if you have any questions about the paperwork or on the proofs you need to send.

After this packet has been returned with required documentation, and approved for services, we will make your appointments for services that will be covered by the program. These generally include a clinical breast exam, pelvic and pap. Also, a mammogram is covered if age appropriate. If any additional tests are suggested you must contact us prior to services for approval, or you will be responsible for the bill.

Please complete all paperwork and return with proof of income and identification as soon as possible. No appointments can be scheduled until paperwork is received.

Thank you,

Christy Guinn
PSWH Clerical Staff

Kayla Hilt, LPN
Public Health Nursing Coordinator

COMPLETE THE HIGHLIGHTED PORTIONS ONLY

Illinois Breast and Cervical Cancer Program

ABNORMAL BREAST SCREENING CARE PLAN AND FOLLOW-UP REPORT

Name: _____ **Cornerstone #:** _____ **Birth Date:** _____

SCREENING INFORMATION				
CBE	Date: _____/_____/_____	Result: _____	Site: _____	Provider: _____
Mammogram	Date: _____/_____/_____	Result: _____	Site: _____	Provider: _____
MRI (high risk)	Date: _____/_____/_____	Result: _____	Site: _____	Provider: _____
	Reminder: Abnormal CBE with negative screening mammogram requires diagnostic follow-up			

BASIC NAVIGATION ASSESSMENT

Complete for ALL clients with abnormal results.

Assessment Date: _____/_____/_____

1. Do you have communication difficulties? ☐ Deaf ☐ Blind ☐ Other Handicap ☐ None
2. Do you speak English? ☐Yes ☐ No If no, primary language: _____
3. Do you read/write English: ☐Yes ☐ No
4. Barriers to keeping appointments:
   ☐ Transportation ☐ Child/family care ☐ Work schedule ☐ Understanding medical needs ☐ None
   ☐ Lack of money ☐ Lack of interpreter ☐ Travel Distance ☐ Making appointments ☐ Other: _____
5. What concerns do you have?
   ☐ Discomfort/pain ☐ Embarrassment ☐ Fear of cancer ☐ Overwhelmed by information ☐ Other: _____
   ☐ None

Comments: _____

_____

See Case Notes: ☐ In chart ☐ In Cornerstone

☐ ***Short-term Follow-up*** (check the box if this cycle is a short-term follow-up)
Are there changes from the previous navigation assessment? ☐ Yes ☐ No If yes, document in the case notes.

INTERMEDIATE AND ADVANCED NAVIGATION ASSESSMENT

Complete ONLY for clients undergoing invasive procedures or that have a cancer diagnosis.

Assessment Date: _____/_____/_____

6. Do you have someone you can talk to? ☐Yes ☐ No
7. If needed, do you have someone to help around the house? ☐Yes ☐ No
8. If you have several appointments for testing or treatment, will you need transportation assistance? ☐Yes ☐ No
9. Would you like to belong to or participate in a support group? ☐Yes ☐ No
10. What concerns do you have?
    ☐ Discomfort/pain in procedure ☐ Overwhelmed by information ☐ Relationship with family/friends
    ☐ Loss of employment ☐ Body image (alteration in body) ☐ Feelings or anger, sadness
    ☐ Fear of cancer ☐ None ☐ Other: _____

Comments: _____

_____

See Case Notes ☐ In chart ☐ In Cornerstone

GENERAL NEEDS- Based on Navigation Assessment

☐ Assistance with scheduling appointments: _____ Date: _____

☐ Transportation arrangement: _____ Date: _____

☐ Child care/adult day care arrangements: _____ Date: _____

☐ Arrangements made for interpreter: _____ Date: _____

☐ Referred to fiscal department or hospital foundation at: _____ Date: _____

☐ Referred to Social Services for counseling/support: _____ Date: _____

☐ Referred to Healthcare and Family Services (HFS) for Treatment Act Date: _____

Accepted for Treatment Act ☐Yes ☐ No RIN # _____ Date: _____

Referral or contact information provided for

☐ Reach to Recovery ☐ Cancer Information Services (CIS) ☐ American Cancer Society (ACS)
☐ Cancer Care/ Avon Cares ☐ Patient Advocate Foundation ☐ Gilda's Club
☐ Lynn Sage ☐ Migrant Clinicians Network ☐ Other_____

OVER

Illinois Breast and Cervical Cancer Program
Eligibility Determination Form

Shaded area is for IBCCP office use only

☐ **New Client** Registration Date: _____	☐ **Established Client** Annual Date: _____	☐ **Navigation Only** Date: _____	**Cornerstone #** _____

Name: _____

Previous Last Name: _____

Age: _____ Birth Date: _____/_____/_____

Address: _____

City: _____ State: _____

Zip Code: _____ County: _____

Home Phone: _____

Cell Phone: _____

Day Phone: _____

Medical/Insurance Coverage: *Check all that apply.*

☐ Medicare Part B – Not eligible for IBCCP
☐ Medicaid ID number _____
☐ I DO NOT have insurance
☐ I have Insurance – Name of Carrier:_____
☐ Are you covered under a parent or spouse insurance?
☐ No ☐ Yes

If yes, Insurer Name: _____

Does insurance pay for: Pap tests? ☐ No ☐ Yes
Mammograms? ☐ No ☐ Yes

Do you have a deductible that must be met before diagnostic procedures are covered? ☐ No ☐ Yes

Please provide a copy of the front and back of your insurance card.

Employment Status:
☐ Employed full-time (35+ hours weekly) (EFT)
☐ Employed part-time (EPT)
☐ Not in the labor force (NLF)
☐ Seasonal/Migrant Farm Worker (SMF)
☐ Self-employed (SE)
☐ Temporary Worker (TW)
☐ Unemployed (UNE)

Marital Status:
☐ Never Married (01)
☐ Married (02)
☐ Other: _____

Years of Education Completed:
☐ _____ (EO # of years)
☐ Unknown (E099)

Income determination:

(circle one)
Total income before taxes (if married - total combined income before taxes): $_____ per month/year

Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: _____

Office Use Only: Income status for number in household:
At or below 250% of federal poverty level: ☐ Above 250% of federal poverty level: ☐

Are you of Hispanic or Latino origin?
☐ Yes (01) ☐ No (00)

Preferred language for delivery of service:
☐ English (E)
☐ Spanish (S)
☐ Other (O):_____

What races do you consider yourself? Mark ALL that apply.
☐ White
☐ Black or African American
☐ Asian
☐ Chinese ☐ Indian ☐ Japanese
☐ Vietnamese ☐ Korean ☐ Filipino
☐ Other_____
☐ Native Hawaiian/Other Pacific Islanders
☐ American Indian/Alaskan Native

How did you hear about this program?
☐ Poster (PO) ☐ Newspaper (ME)
☐ Flier (FL) ☐ Radio (ME)
☐ Brochure (BR) ☐ Television (ME)
☐ Community Navigator (C) ☐ Website (Agency/State) (WB)
☐ Community Event (CE)
☐ Physician or Health Care Provider (P)
Who: _____ Phone #: _____
☐ Other (OTH), Specify: _____

Barriers:
☐ None ☐ Transportation ☐ Child/family Care ☐ Work schedule
☐ Understanding medical needs ☐ Special needs ☐ Financial
☐ Need Interpreter ☐ Travel Distance ☐ Making appointments
☐ Other: _____

Comments:
_____
_____

What is the best time to schedule your appointments?
(Please mark your choices.)

Preferred Healthcare Provider: _____

Day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time of day: ☐ Early morning ☐ Mid-morning ☐ Early afternoon ☐ Late afternoon

I certify that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature X _____ **Date** _____

IBCCP Health Assessment

Name: **Date:**

YES	NO	BREAST HEALTH QUESTIONS
☐	☐	1. Do you perform a monthly breast self-exam?
☐	☐	2. Have you noticed a lump in your breasts?
☐	☐	3. If yes, which breast? Right___ Left____
☐	☐	4. Have you noticed any breast tenderness or pain?
☐	☐	5. If yes, did the breast tenderness or pain increase around the time of your menstrual period?
☐	☐	6. If you answered yes to question #4, which breast? Right _____ Left_____
☐	☐	7. Have you noticed any spontaneous discharge (not from stimulation or squeezing) from your nipples?
☐	☐	8. If yes, which breast? Right _____ Left_____
☐	☐	9. Have you noticed any other symptoms related to your breasts? If yes, explain: _____
☐	☐	10. Have you ever had a breast exam done by a doctor or nurse?
☐	☐	11. If yes, list provider/clinic where breast exam was done: _____
☐	☐	12. If yes, date of last exam (before this current visit): _____/_____
☐	☐	13. Have you ever had a mammogram?
☐	☐	14. If yes, list provider/clinic where mammogram was done: _____
☐	☐	15. If yes, date of last two mammograms (before this current visit):___/_____, ____/_____
☐	☐	16. If unknown was it more than 5 years?
☐	☐	17. Have you ever had breast cancer?
☐	☐	18. Has your mother, sibling (sister/brother) or daughter had breast cancer? If no, go to question 22.
☐	☐	19. If yes, who _____
☐	☐	20. Are they BRCA positive (if known)?
☐	☐	21. If yes, at what age? _____ years old
☐	☐	22. Do you have a breast implant or implants?
☐	☐	23. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
☐	☐	24. If yes, which breast? Right _____ Left_____
☐	☐	25. If yes, list the provider who performed the procedure_____
☐	☐	26. Have you ever had radiation to the chest area?

YES	NO	CERVICAL HEALTH QUESTIONS
☐	☐	27. Have you ever had a Pap test?
☐	☐	28. If yes, list provider where Pap test was done: _____
☐	☐	29. If yes, date of last two Pap tests: (before this current visit): ____/____, ___/____
☐	☐	30. If unknown was it more than 5 years?
☐	☐	31. Were your last Pap test results normal?
☐	☐	32. What was the date of your last menstrual period? _____/_____/_____
☐	☐	33. Are you pregnant?
☐	☐	34. Have you had a hysterectomy?
☐	☐	35. If yes, was your cervix removed? I do not know_____
☐	☐	36. If you had a hysterectomy, was it due to a past history of cervical disease or cervical cancer?
☐	☐	37. Were you exposed to Diethylstilbestrol (DES)?
☐	☐	38. Is your immune system weakened in any way? (medication, HIV, organ transplant or other health condition)

YES	NO	TOBACCO QUESTIONS
☐	☐	39. Do you smoke cigarettes?
☐	☐	40. If yes, are you ready to quit smoking?
☐	☐	41. If yes, are you interested in being referred to the Illinois Tobacco Quitline?

(Shaded area for IBCCP office use)

42. What date was the referral sent to the Tobacco Quitline? _____/_____/_____

BARRIER/RISK ASSESSMENT QUESTIONS

Barrier Assessment

43. from Eligibility Determination form

Breast Cancer Risk Assessment

(from Summary Office Visit form)

44. Life time risk_____

45. High risk for breast cancer
- ☐ yes
- ☐ no
- ☐ not assessed/unknown

Cervical Cancer Risk Assessment

46. High risk for cervical cancer
- ☐ yes
- ☐ no
- ☐ not assessed/unknown

OVER

PLEASE READ AND SIGN ON PAGE 3

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION

I. PROGRAM DESCRIPTION:

The Illinois Breast and Cervical Cancer Program (program) is a cooperative effort between the Illinois Department of Public Health, Office of Women's Health and Family Services, and the U.S. Centers for Disease Control and Prevention (CDC). The program encourages routine breast and cervical cancer screening and provides free screening and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screening is to detect cancer, if present, at an early stage so it can be treated or cured. Screening for breast cancer involves a clinical breast examination and a mammogram (a breast X-ray). Screening for cervical cancer involves a pelvic examination and a Pap test (scraping from the cervix).

II. CONSENT TO PARTICIPATE AND RELEASE OF INFORMATION:

I understand and agree to the following:

- I will provide proof of age and income to determine program eligibility. If I have insurance coverage, I will provide a copy of my insurance card and written verification of covered services. If while enrolled in IBCCP I obtain insurance, I will inform Lead Agency staff.

- I give permission to my health care provider(s), insurance company, hospital, clinic, laboratory and/or mammography facility to provide information concerning my breast and cervical cancer screening, diagnostic examinations and/or treatment status to program staff.

- I understand that the program must obtain certain statistical information for reports, including but not limited to age, income, insurance and any services I am provided through this program. This information may be used by the program and the CDC to learn more about breast and cervical cancer and to ensure the quality of services provided through the program. **My name will not be used in these reports, except as required by law.**

- My health care provider and/or the program staff will try to contact me regarding my test results. I understand that, despite efforts to find me, my health is my own responsibility and I may need to contact my provider for my test results.

- I understand that if the provider orders tests not covered by the program or my insurance that I may be responsible for payment of those IBCCP services as the program cannot pay for some diagnostic exams. A list of allowable services is available upon request.

- If I am diagnosed with a pre-cancerous or cancerous condition of my breasts or cervix, information from my IBCCP file will be released to the Illinois Department of Healthcare and Family Services. This information will be used to determine if I am eligible for state paid health benefits through Medicaid.

- If I am not eligible for Medicaid coverage, the program staff will assist with referral for treatment services through private sources, community based sources, other governmental grants or pro bono from a provider.

- If I am eligible for state paid health benefits through Medicaid, I give my permission for program staff to obtain information about my treatment for breast or cervical cancer. This information will be used to determine my treatment status and my continued enrollment in Medicaid.

- I will receive notification from the program staff to remind me when it is time for me to go back to my medical provider for my annual examination and follow-up testing, if appropriate (This does not apply to insured clients).

- I will notify the program of any change in my address and/or telephone number.

- I will write or call the local program staff to inform them if I no longer wish to be a part of this program. This notification will be recorded in my program records.

- I understand the importance of keeping all appointments made for me so my care can be provided in a timely manner. When it is necessary to cancel or change an appointment, I will notify the agency of this change.

- Missed appointments or repeated “no show” appointments are not acceptable and I can potentially lose my ability to receive IBCCP services if this happens.

OVER

III. ACKNOWLEDGMENTS:

- I have received literature and/or education on all of the following: breast health, mammograms, and Pap tests. _____ (initial here)

- The University of Illinois at Chicago (UIC), an IBCCP partner, conducts an annual survey for the purpose of helping the Department improve the quality of the program so that the Department can provide better services to program participants. UIC will be contacting you about this survey at a future date. We hope that you will participate, but your participation is completely voluntary, and your program eligibility will not be affected if you choose not to participate. Your initials here acknowledge that you have received notification of this voluntary survey. _____ (initial here)

Client Signature X _____ **Date** _____

Prairie State Women's Health

11191 Illinois Route 185
Hillsboro, IL 62049
Ph. 217-532-2001 * Fax 217-532-6676

Age Verification

All applicants must fill out the Statement of Age Verification below.

You must send a copy of your driver's license, state ID, passport or birth certificate.

We will accept this page as your proof of age and residence.

STATEMENT OF AGE VERIFICATION

I, _____, hereby attest that I was born on

_____, and that I currently reside at

_____.

Signature X_____Date _____

OVER

PLEASE READ AND SIGN

ILLINOIS BREAST & CERVICAL CANCER PROGRAM

EXPLANATION OF PAYMENT PROCEDURE

I, _____ , do hereby understand the explanation of the Illinois Breast and Cervical Cancer Program and attest that all of the procedures, payment schedule and charges have been fully explained to me.

I also understand that any charges incurred for services not listed on the reimbursement payment schedule for the IBCCP are solely my responsibility.

Name (please print) X _____

Name (signature) _____ 

Date _____

COMPLETE AND SIGN

Montgomery County Health Department
Client Eligibility Screening

Name_____

PLEASE ANSWER YES OR NO

Do you have health insurance? Yes ☐ No ☐
If yes, name of provider_____
Medicaid #_____ (Spend-down $_____ Amt $_____)
Medicare #_____
(Part B Deductible $_____Amt $_____ Met $ _____)
Other (specify)_____Co-pay $_____Amt $_____)

Income Determination

# In Household (A)	Client Income (B) Monthly	Annually
1		
2		
3		
4		

PLEASE MAKE A COPY OF PHOTO ID AND GROSS HOUSEHOLD INCOME - SIGN AND DATE BOTH COPIES

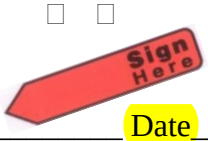
ELIGIBILITY VERIFICATION

Age verification Age_____ Birthdate_____

From: Driver's License ☐ Illinois I.D. ☐ Other ☐

Income verification:

	Yes	No
Food Stamps	☐	☐
Public Aid	☐	☐
Pay Stub or W-2	☐	☐
Signed Verification Statement	☐	☐
I am unable to produce income verification	☐	☐



Signature X_____ Date_____

Case Manager_____ Date_____

Client is eligible for the IBCCP program? Yes ☐ No ☐

OVER

COMPLETE ONLY IF YOU HAVE NO INCOME

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM
NO-INCOME AFFIDAVIT

I, _____, hereby certify the following:
Print Name

Please check all that apply:

☐ I am over the age of 18 and currently am unable to remain in my residence. I will be admitted to hospice imminently.

☐ Prior to my cancer diagnosis, I earned approximately $_____/year.

☐ I currently do not earn, and do not expect to earn over the next twelve months, income from any employer; and I do not receive any supplemental income from any public or private sources; and

☐ I do not receive any ongoing payments from rents, royalties, recurring gifts, hobby income, insurance payments, disability or unemployment benefits, retirement income, investment income; etc.

This affidavit is made under penalty of perjury. Any fraudulent or untrue Statements made in this affidavit will result in denial of Health Benefits for Persons with Breast or Cervical Cancer and/or possible legal action.

Signature X _____ Date: _____

Witness to Signature: _____ Date: _____

PLEASE COMPLETE FORM AND SIGN

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM
INCOME AFFIDAVIT

I, _____, hereby certify the following:

Client Household and Income Worksheet

CLIENT NAME: _____ LEAD AGENCY: _____

Please list **all** persons living in the household on the worksheet. This includes client, spouse, children, step-children, grandchildren, elderly parents, other family members or non-family members residing in the household.

Household Member	Relationship	Age	Employment Income (Monthly)	Other Income (Monthly)	Source of Other Income*
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

*Other Income may include: Social Security, child support, spousal support, rental property, unemployment benefits, pensions and trusts.

Total Household Size (include only client, spouse, and children or stepchildren of the client who are under age 19) _____

Total Income (include income from only the individuals included in the total household size) $ _____

This affidavit is made under penalty of perjury. Any fraudulent or untrue Statements made in this affidavit will result in denial of Health Benefits for Persons with Breast or Cervical Cancer and /or possible legal action.

Signature X _____ **Date:** _____

SIGN HERE

OVER

PLEASE READ & COMPLETE FORM AND SIGN

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH AND FAMILY SERVICES
BREAST AND CERVICAL CANCER PROGRAM

AUTHORIZATION TO OBTAIN INFORMATION

I hereby give consent to release the following information:

- ☒ Clinic Report
- ☒ Medical Reports
- ☒ Laboratory Report
- ☒ Other Billing

Regarding:
Client's Name: _____

Client's Address: _____

Date of Birth: _____/_____/_____

To: Agency Name & Address, ATTN: Illinois Breast & Cervical Cancer Program

Prairie State Women's Health / Montgomery County Health Department

11191 Illinois Route 185

Hillsboro, IL 62049

Phone: (217) 532-2001

I agree to release said provider, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice. Unless I revoke sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photo static copy or facsimile of this consent will be valid as the original, even though such copy does not contain the original writing of my signature.

X _____ SIGN HERE _____
Signature Date

_____ _____
Witness Date

PLEASE COMPLETE FORM AND SIGN

CONSENT and ACKNOWLEDGEMENT
Receipt of Joint Notice of Privacy Practices

I, _____(print name of client) do hereby consent to allow Prairie State Women's Health/Montgomery County Health Dept. (agency name) and its designated employees and contractors to perform:

- Pelvic and/or breast examinations and screenings and
- Necessary diagnostic follow-up tests

I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the agency dated August 21, 2013.

X _____ Sign Here
Signed

_____
Date

FOR STAFF USE ONLY:
I attempted to obtain an Acknowledgement of the Receipt of the Notice of Privacy Practices on behalf of the delegate agency. The agency was unable to obtain the Acknowledgement because:

☐ Client refuses to sign
☐ Other _____(specify)

_____ Staff member's initials _____ Date

(Staff: Place Acknowledgement in patient's medical record.)

OVER

PLEASE LIST DOCTOR, HOSPITAL AND THEIR ADDRESSES AND SIGN ON BACK

Montgomery County Health Department
Authorization for Release of Information
(45 CFR~164.508)

I hereby authorize the use or disclosure of protected health information about me as described below.

1. The name or other specific identification of the person(s) or class of persons, authorized to make the use or disclosure: **Name Address Phone Number**

   Doctor: _____

   Hospital: _____

2. The name or other specific identification of the person(s) or class of persons to whom the requested disclosure may be made:

   Montgomery County Health Department designated IBCCP staff.

3. Specific description of the information to be used or disclosed:

   Clinical Breast Exam: Pelvic Exam: Pap smear:

   Mammogram:

   Other test ordered per IBCCP

4. The information may be used or disclosed for each of the following purposes:

   IBCCP and Treatment Act.

5. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

6. I understand that I may revoke this authorization by notifying the Montgomery County Health Department in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by the Montgomery County Health Department in reliance on this authorization.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

PLEASE SIGN BELOW

8. I understand this authorization will expire on (check and complete one):
   _____ _____, 20__, OR
   _____ On the happening of the following event that relates to me or the purpose of the use or disclosure: _____

_____

_____

_____

This form has been fully completed before signing.

SIGN HERE

X _____
Signature of Patient or Representative

_____
Patient's name

X _____, 20____
Date

ID number _____

_____

_____
Patient's address

_____
Name of patient's representative (if applicable)

_____

_____
Description of Representative's Authority to act for patient

_____ _____, 20_____
MCHD witness date

A copy of this fully completed and signed must be given to the client.

1/03

OVER

PLEASE COMPLETE FORM AND SIGN BELOW

STATE OF ILLINOIS
CORNERSTONE
CORNERSTONE INFORMED CONSENT FORM

Name of Participant:

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (Month/Day/Year) _____ ◯ Male ◯ Female Participant s ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; Healthy Families Illinois; and Family Health History Questionnaire/Genetics.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Department of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client s name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize Prairie State Women's Health / MCHD (Cornerstone site) to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal; birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program; and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared;

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Department of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photostatic copy/fascimile of this consent will be as valid as the original.

For Child Participant: _____ OR For Adult Participant: X _____ SIGN HERE

Signature of parent/legal guardian/caretaker/Date Signature of adult participant/Date

Signature of Witness: _____ Date: _____

Revised April 2011

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM ENROLLMENT PACKET

C H E C K L I S T

Please complete the attached enrollment papers to the best of your knowledge. ***Signing and dating*** of required forms will be necessary prior to our being able to schedule your appointments. Simply check them off as you complete them.

☐ **Eligibility Determination Form**
Complete, sign & date

☐ **Health Assessment** (Breast and Cervical Screening Questions)
Complete to the best of your knowledge

☐ **Cornerstone Consent Form**
Please read the entire form and then complete, sign & date. This gives IBCCP Personnel permission to enter the information you provided into our computer system. Only the IBCCP Personnel have access to this information. This allows the IBCCP Personnel to keep your breast and cervical cancer screenings up-to-date, on a yearly basis.

☐ **Client Participation Agreement & Release of Information**
Please read, sign & date

☐ **Authorization to Obtain Information**
Please read, sign and date

☐ **Joint Notice of Privacy Practices and Consent**
Please read, sign and date

Please include the following verification with your enrollment/re-enrollment packet.

☐ **Income** Verification (2 most recent paycheck stub or recent 1040 tax form)
☐ **Age** Verification (copy of your driver's license, ID card or birth certificate)
☐ **Medicaid Verification** (copy of your card)
☐ **Insurance Verification** (copy of the front and back of your card)