Application for Services

Please complete the attached application and turn it in with proof of income for your household. Proof of income may include: copy of recent check stub, proof of direct deposit amount, statement from employer of income and hours worked or signed statement that indicates that you have no income.

Please fax, mail or bring the application and requested information to our office at:

Abilene-Taylor County Public Health District
Attn: BCCS Program
850 N. 6th
Abilene, TX 79601
Fax 325-734-5366
Amy.Fulcher@abilenetx.gov

Please allow up to 10 days for processing. Call 325-437-4662 if you have any questions.

Thank you.

APPENDIX A

DSHS Family & Community Health Services Division
INDIVIDUAL Eligibility Form

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address		
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP	
SSN (optional)	Date of Birth	Age	Race	Ethnicity	Sex

a) Please contact me by: (check all that apply) ☐ Mail ☐ Phone ☐ Email

b) Do you have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? ☐ Yes ☐ No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐ Medicaid for Pregnant Women ☐ TWHP ☐ None

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s).

How many people are in your household? ☐

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. ☐ Yes ☐ No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to me.

____ ____________________

Signature – Applicant Date

____________________________ ____________________ ____________________

Signature – Person who helped complete this application Relationship to Applicant Date

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

Eligibility effective date / /

1. Texas resident ☐ Yes ☐ No
2. Total monthly household income $
3. Household FPL %
4. Proof of income ☐ Yes ☐ Waived
5. Verification of adjunctive eligibility ☐ Yes ☐ No ☐ n/a

6a. Presumptively eligible ☐ Yes ☐ No ☐ n/a

6b. Full eligibility met ☐ Yes

6c. Full eligibility met date / /

7. Is the client eligible for the following program(s)?

	Yes	No	n/a	Co-payment amount (if applicable)
BCCS	☐	☐	☐	$__________
DSHS FP	☐	☐	☐	$__________
EPHC	☐	☐	☐	$__________
PHC	☐	☐	☐	$__________
Title V/MCH	☐	☐	☐	$__________

Notes:

____________________ ____________________ ____________________

Name of Agency Signature – Agency / Staff Member Date

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

a) Check all the boxes that apply.

b) Check *yes* or *no*.

c) Check all the boxes that apply:

- *CHIP (Children's Health Insurance Program) Perinatal*
- *Medicaid for Pregnant Women*
- *SNAP (Supplemental Nutrition Assistance Program)*
- *TWHP (Texas Women's Health Program)*
- *WIC (Special Supplemental Nutrition Program for Women Infants and Children)*
- *None*

If you selected one of these benefits or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services.)

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Fill in the table with the following information:

1st column: The name of the person receiving the money.
2nd column: The name of the agency, person, or employer who provides the money.
3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT

Rights and Responsibilities:

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). *(MBCC clients are not required to report changes in income, household, and residency)*

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months *(not applicable to MBCC)*.

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Read the **Rights and Responsibilities** above. Check *yes* or *no*.
Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

(1) Check the appropriate box (*yes* or *no*) for Texas resident. (2) Total the *amount received per month* to fill in the *Total monthly household income* box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the *Household FPL* box. Check the appropriate box (*yes, no, waived,* or *n/a*) for (4) *Proof of* income and (5) *Verification of adjunctive eligibility.*

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (*yes, no,* or *n/a*) for *Presumptively eligible.* Once the client completes the requirements for full eligibility, (6b) check *Yes* for *Full eligibility met* and fill in the (6c) *Full eligibility met date* box.

(7) Check the appropriate box (*yes*, *no*, or *n/a*) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.
Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

Additional program eligibility questions

1. Preferred Language: ____

2. Marital Status:

□ never married □ currently married □ formerly married

3. Please answer the following questions about your birth control status.

List your current birth control method: ____________________________

If no method please select a reason:

□ Tubal/sterile □ Hysterectomy □ Menopause □ Seeking Pregnancy □ Refuse □ Rely on Partner
□ Other: _________________________

Have you ever taken hormones? (Birth control pills, hormone replacement therapy, etc.)? □ Yes □ No

If yes, how many years total did you take hormones? _________ What type?_______________________________

4. **Pregnancy history**

List the number of times you've been pregnant: __________________________

List the number of times you've given birth: ______________________________

List your number of living children: _____________________________________

5. PAP Smear history

When & where was your last Pap smear or pelvic exam? (Where)____________________(When)_______________

Was your Pap smear □ Normal □ Abnormal □ Unknown

Have you ever had an abnormal Pap smear or Pelvic Exam? □ Yes □ No If yes, when? _____________________

Have you ever had a procedure after an abnormal Pap smear? □ Yes □ No

If yes, when and where? ____

6. Breast history

When was your last clinical breast exam (in a clinic or doctor's office)? ____________________________________

Was your last clinical breast exam normal? □ Yes □ No If no, why? ________________________________

When was your last mammogram? ________________________ Where? _________________________________

Have you had any type of breast surgery or biopsy? □ Yes □ No If yes, when? ____________________________

Do you have a personal or family history of breast cancer? □ Yes □ No If yes, whom? ______________________

7. Symptoms

Are you currently experiencing any breast or pelvic symptoms? □ Yes □ No

If yes, what are your symptoms? ____

TEXAS Health and Human Services Commission

Texas Health and Human Services Commission (HHSC)
Breast and Cervical Cancer Services (BCCS)

Patient Navigation Form

Contractor, Clinic Name:	Patient Navigator:	Patient ID #:	Chart #:

CLIENT INFORMATION

Patient Name:	Date of Birth:	Daytime Phone:
Alternate Contact Name:	Relationship:	Daytime Phone:

PATIENT NAVIGATION CONSENT - Required for patients receiving navigation services

I understand and agree to have ongoing assessment for needs and care coordination planning, and may need additional evaluation because my test results are abnormal.

Signed:____ **Date**:________________________________

FOR AGENCY USE ONLY - PATIENT NAVIGATION WORKSHEET

Contractors may use an approved alternate patient navigation form if worksheet content and client consent to navigation are included. Alternate forms must be submitted to HHSC for consideration and written approval must be kept on file for Quality Assurance visits.

Date Started:	Screening/Diagnostic Results:	
Navigation Need	**Barriers**	**Activities**
☐ MBCC Application ☐ Cervical Dysplasia Treatment ☐ Breast Diagnostics ☐ Cervical Diagnostics	☐ Childcare ☐ Fear ☐ Language barrier ☐ Pregnant ☐ Education ☐ Transportation ☐ Financial ☐ Psychosocial ☐ Schedule/Work ☐ Family Issues ☐ Other ________________	☐ Provide Education ☐ Financial Assistance Referral ☐ Social Work Referral ☐ Psychosocial Support ☐ Translator/Language Services ☐ Schedule Appointment ☐ Transportation Assistance/Referral ☐ Community Resources Referral ☐ Flex Appointment Time/Place ☐ Childcare Resources Referral ☐ Pregnancy Resources Referral ☐ Other ________________________

REFERRALS AND FOLLOW UP

Activity	Service Provided	Date of Service	Follow Up Date	Outcome of Service or Referral

DATE CLOSED: __________________ REASON CLOSED: __________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize all Hospitals, Physicians, Surgeons and Health Clinics to disclose copies of health information (including any and all individually identifiable health information under HIPAA regulations) identified below pertaining to history, diagnosis, treatment or prognosis. This information may be disclosed to the Abilene-Taylor County Public Health District, 850 N. 6th, Abilene, Taylor County, Texas, 79601, (325) 437-4662. The purpose of this disclosure is for assistance in the early detection of breast/cervical cancer. The disclosure permitted by this authorization includes the following: **Results of clinical breast and/or cervical examination, mammography and ultrasound results and/or films, pap test results, colposcopy results, biopsy results, consultation notes, reports resulting from any further diagnostic procedures necessary for the detection of breast and/or cervical cancer and documents verifying citizenship.**

I hereby authorize Abilene-Taylor County Public Health District to enter pertinent medical and case management and other personal information into the MED-IT statewide database as required by the Department of State Health Services. Such information is entered for the purposes of billing and case management of my medical needs and continued procedures. My signature on this release also authorizes the Abilene-Taylor County Public Health District to view my BCCS clinical services/data history that has been stored in the state-wide database (MED-IT).

Furthermore, I hereby authorize Abilene-Taylor County Public Health District to release the above health and personal information concerning my screening for breast and/or cervical cancer for the purposes of case management, referral and follow up, including any final diagnosis, to the facilities where the screening or diagnostic procedures are performed, the healthcare provider who initially referred me for screening or diagnostic procedures, the physicians/surgeons to whom I may be referred for additional diagnostic procedures and representatives from organizations that may be able to assist with case management needs. I understand that release of information to any additional health care providers must first have my written approval. In addition, I understand that if my records are subpoenaed by a court of law, my records will be copied and submitted to the court as requested.

Furthermore, I hereby authorize the Abilene-Taylor County Public Health District to report my information to those third parties which supply funding for the Abilene-Taylor County Public Health District. I understand that this authorization for release of health information will expire two years from the date of signature unless otherwise revoked.

In addition to those listed above, I hereby authorize Abilene-Taylor County Public Health District to release information to:

- Spouse ______________________________
  Name Address Phone #
- Children ______________________________
  Name Address Phone #
- Other ______________________________
  Name Address Phone #
- Information is not to be released to anyone.

Notice to Individual:

(1) I understand that this authorization is voluntary, that I may refuse to sign this authorization, and that I have the right to revoke this authorization in writing.

(2) I understand the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and that it may no longer be protected by HIPAA privacy regulations.

______________________________ ______________________________

Patient Signature Date of Signature

____

Print Patient Name Date of Birth

What Do I Need to Know About Screening for Breast & Cervical Cancer?

Although every woman is different, here are some common questions that women have.
What is cancer?

- A growth inside the body
- Usually too small to see or feel when it first begins
- The growth will get larger and spread to other parts of the body if not treated

What are the main risk factors for breast cancer?

- Being a woman age 50 or older
- Having a personal family history of breast cancer
- Smoking increases the risk of breast and other cancers

What are the main risk factors for cervical cancer?

- Having unprotected sexual intercourse and/or sexually active before the age of 18
- Multiple sexual partners and/or sexual partners who have other sexual partners
- History of Sexually Transmitted Diseases (STD) and/or Human papilloma virus (HPV)
- History of Abnormal Pap Smear
- Smoking increases the risk of cervical and other cancers

What can I do to try to find breast and cervical cancer as early as possible?

- Monthly breast self-exam
- Annual clinical breast exam by a healthcare provider, beginning at age 18
- Regular mammogram (every other year for ages 40-49; annually thereafter)
- Regular pap smear

Why is it important for me to be screened at regular intervals?

- Your doctor and/or radiologist can more easily detect an early cancer from slight changes that occur in the breast and/or cervix from one year to the next
- Fibrocystic breasts are more difficult to examine and can hide small changes
- Earlier treatment improves the chance of less invasive cervical treatment and saving not only your breast, but your life!

What symptoms should I look for?
There are no known symptoms of cervical cancer. Cervical cancer can only be detected with a tissue biopsy although a pap smear can help detect abnormal or precancerous cells.
Symptoms of breast cancer can include the following and you should call your doctor immediately if you find**:**

- Lump or thickening in or near the breast or underarm
- Change in the size or shape of the breast
- Discharge from the nipple
- Change in the color or feel of the breast, areola or nipple

Eligibility may change from year to year therefore your application will expire one year from the date it was completed.

Please sign below to acknowledge that you have read the above information. Please do not hesitate to ask questions if you want or need more information!

Patient Signature: ____ Date: _______________________