The Health Department of Northwest Michigan offers a Breast and Cervical Cancer Control Navigation Program (BCCCNP). This screening program, supported by the Federal Government and the Michigan Department of Health and Human Services, is part of a national plan to reduce the number of women without health insurance who die of breast or cervical cancer.

**PURPOSE OF THIS PROGRAM**
The purpose of the BCCCNP is to find out if a woman has breast or cervical cancer and, if she has cancer, to assist her in obtaining cancer treatment. Regular screening tests can help find a cancer that may be present when it is still very small and easier to treat.

**WHAT THE PROGRAM OFFERS TO YOU**
Eligible women who meet the program income guidelines can receive the following services:

**BREAST**
- Women ages 40-64: breast screening test (mammogram) and/or follow-up tests (if needed) for an abnormal finding on a mammogram.
- Women ages 21-39: referred to BCCCNP with an abnormal clinical breast exam (CBE) and requires breast diagnostic services.

**CERVICAL**
- Cervical cancer screening includes a Pap test and HPV test (if indicated) according to the client’s age.
  - Women ages 21-29: Pap test ONLY – HPV testing is unacceptable for this age group and not payable by the BCCCN program.
  - Women ages 30-65: Pap test and HPV testing as per BCCCNP medical protocol and cervical screening eligibility guidelines.
  - Women ages 21-64: referred to BCCCNP for cervical follow-up tests for an abnormal finding on a cervical screening test.

**PROGRAM ELIGIBILITY:** (INITIAL________)
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 DOES NOT cover breast/cervical cancer screening and/or follow-up services OR
   - My health insurance has a large deductible that must be paid prior to my receiving services and I am unable to pay the deductible.

2. If I gain insurance after I’ve enrolled, I must notify the BCCCNP 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.

3. The BCCCNP is available to women who live in Michigan or live near the border of a neighboring state (Indiana, Ohio, Wisconsin, Minnesota) who plan to receive screening and diagnostic services in Michigan.
   - I must notify the BCCCNP if my residency status changes.
   - If I provide incorrect information about being a Michigan resident or receiving services in Michigan, I will not be eligible for any further services and will be dis-enrolled from the BCCCNP.

**NOTIFICATION OF TEST RESULTS AND FOLLOW-UP OF ABNORMAL RESULTS:** (INITIAL________)
1. I will be informed of the results of these screening tests and of any additional follow-up that may be needed.
2. Follow-up tests are offered following an abnormal breast and/or cervical cancer screening result.
3. It is my choice whether or not to follow the recommendations for follow-up of any tests that are abnormal.
4. If any screening test shows something that is abnormal, the BCCCNP agency will help me schedule follow-up exams through providers participating in the program.
5. If I have another provider, s/he will be informed of test results if I provide written approval to release this information.

**COST OF PROGRAM SERVICES:** (INITIAL__________)

1. The costs of program-approved breast and/or cervical cancer screening and follow-up tests are covered by the program.
2. It is possible there may be other tests or procedures recommended to me by my provider.
   • If those recommended tests are not program-approved the BCCCNP cannot pay for those follow-up tests, exams, and/or additional charges.
   • If I am unable to pay, the BCCCNP agency will work with me to help me receive needed services. (i.e. financial assistance and setting up a payment plan if needed)
3. I understand that I should ask the BCCCNP 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.

**IF BREAST OR CERVICAL CANCER IS DIAGNOSED:** (INITIAL__________)

1. The BCCCNP does not pay for any treatment services for breast or cervical cancer.
2. If breast or cervical cancer is diagnosed, the BCCCNP agency will determine if I am eligible to participate in a BCCCNP-specific Medicaid program that will provide insurance coverage for my cancer treatment.
   • By initialing above, I understand that once I have completed cancer treatment and/or am no longer eligible for the BCCCNP, this insurance coverage will end.
3. If I am not eligible for treatment coverage through this Medicaid program, the BCCCNP 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 BCCCNP. 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 screening and follow-up program, I wish to enroll.

The BCCCNP agency phone number is (_______/________-___________).

_________________________________________  ____________
Signature of Client  Date

_________________________________________  ____________
Signature of Witness  Date
The ____________________________ (agency) offers a Breast and Cervical Cancer Control Navigation Program (BCCCNP). This program assists women in obtaining breast and cervical cancer screening and diagnostic services (if needed). If a woman is diagnosed with breast or cervical cancer the program staff will assist her in obtaining cancer treatment. Regular screening tests can help find a cancer that may be present when it is still very small and easier to treat.

I UNDERSTAND THAT:

- Any personal information obtained about me will be treated as confidential.
- Signing this form grants permission for my providers to share my information and test results with BCCCNP staff.
- Information about my tests results will be used by BCCCNP staff to assist me with obtaining care.
- Information about me that does not identify me will be used in grouped reports or for other reporting purposes concerned with controlling breast and cervical cancer.

I GIVE PERMISSION AND AGREE TO:

- Provide the BCCCNP Local Agency and staff administering the program with information about me, including my health history and reports of screening and follow-up tests and procedures relating to breast or cervical cancer.
- Allow the BCCCNP staff to assist me as needed in obtaining breast and cervical cancer screening services.
- Allow the BCCCNP staff to give information regarding my care to:
  - My health care provider
  - Any consulting physician/health care provider
  - Any clinic or hospital to which I may be referred
  - Any other individual agency designated by me
- Have the BCCCNP Local Agency staff contact me in the method I prefer (phone, email) and leave a message for me about my care. (INITIAL) ________________

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 screening and follow-up program, I give permission for BCCCNP staff to obtain my test results.

BCCCNP Agency Phone number is (_______/________-__________).