Health Care Connection

screening for Life

Client ID Number:______________________________ Today's Date: ________________

Please complete and sign this application for the *Screening for Life* (SFL) and *Health Care Connection* (HCC).

- SFL offers breast, prostate, cervical, colorectal, and lung cancer screenings.
- HCC is a referral service that helps you find a doctor who will see you at a lower cost.

For additional information about SFL and HCC, please call **2-1-1** (toll free).

THIS IS NOT INSURANCE

Client Information

How did you hear about the *Screening for Life Program* (SFL) and/or *Health Care Connection* (HCC)?

☐ Newspaper ☐ TV ☐ Internet ☐ Radio ☐ Billboard ☐ Direct mail to residence ☐ Clinic/health center/doctor's office ☐ Hospital
☐ Word-of-mouth ☐ Pamphlet/brochure ☐ Helpline ☐ Other, please specify ______________________________

Last Name: ______________________________ First Name: ____________________ M:________

Maiden Name: ______________________________ Please list any other names that you may have used: ________________

Home Address:______________________________ Apt. No.: ________ PO Box No.: __________

City:______________________ State: ______ ZIP Code: __________________ County: ______________________

Mailing Address (if different from above): ______________________________

Daytime Phone: ________________ Other Phone: __________________ Email Address: ______________________

Primary Language: ☐ English ☐ Spanish ☐ Other:____________________

1. What is the highest level of education you have completed?
☐ Less than high school ☐ Some high school ☐ High school graduate ☐ More than high school

Household members: Tell us who is in your family. For additional household members, use a separate sheet of paper.
How many people are in your household: ____________ (Including yourself)

Last Name	First Name	M	How is this person related to you?	Date of Birth	Sex M=Male F=Female	Social Security	Race*	Hispanic or Latin origin? Y=Yes N=No	Served in Armed Forces? Y=Yes N=No	U.S. citizen? Y=Yes N=No	Legal alien? Y=Yes N=No	Is the person insured? Y=Yes N=No
			Self									

*Races: White (W); Black/African American (B/AA); Asian (A); Native Hawaiian (NH) or other Pacific Islander (PI); American Indian (AI) or Alaskan Native (AN); unknown (u); 2 or more races—indicate which races: ______________________________

Client Eligibility

2. What kind of healthcare coverage do you have? (check all that apply)
☐ Medicare (please circle coverage type below)
Part A Part B SLMB QMB
☐ Medicaid
☐ Tricare, VA benefits
☐ Private insurance (HMO, PPO, etc.)
☐ Other (Please specify.) ____________________
☐ None (Skip to question #5.)

3. This year, does your healthcare coverage pay for:
☐ Pap smears ☐ Mammograms
☐ Colorectal exams ☐ Prostate screenings
☐ Lung cancer screening

4. Have you met your deductible?
☐ Yes (Specify amount of deductible.) $ ____________
☐ No (Specify amount of deductible.) $ ____________
☐ Does not apply

5. Have there been any changes in your healthcare coverage in the past 6 months?
☐ Yes ☐ No
Please specify: ______________________________

6. How long has it been since you had healthcare coverage?
☐ Within the past 6 months (0 to 6 months ago)
☐ Within the past year (6 to 12 months ago)
☐ Within the past 2 years (1 to 2 years ago)
☐ Within the past 5 years (2 to 5 years ago)
☐ 5 or more years ago
☐ Don't know/not sure ☐ Never

7. What is the main reason you are without healthcare coverage?
☐ Lost job or changed employers
☐ Spouse or parent lost job or changed employers
☐ Became divorced or separated
☐ Became ineligible because of age or leaving school
☐ Employer doesn't offer or stopped offering coverage
☐ Cut back to part-time or became temporary employee
☐ Benefits from former employer ran out (COBRA)
☐ Couldn't afford to pay premium
☐ Insurance company refused coverage
☐ Lost Medicaid or Medical Assistance Eligibility
☐ Spouse or parent paid
☐ Other (Please specify.) ______________________
☐ Don't know/not sure

8. What is your income before deductions (gross income)? ________
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

9. Are you (please check all that apply):
☐ Employed for wages ☐ Student
☐ Receiving alimony ☐ Retired
☐ Receiving workers' compensation ☐ Receiving child support
☐ Unable to work ☐ Receiving unemployment
☐ Receiving SSI/SSD ☐ Self-employed
☐ Homemaker ☐ Receiving pension
☐ Out of work more than one year
☐ Out of work less than one year
☐ Receiving Temporary Assistance for Needy Families (TANF)

Access and Use

10. Was there a time during the last 6 months when you needed to see a doctor, but could not because of any of the following reasons? Please read and check all that apply.

☐ Cost ☐ Inconvenient hours ☐ Transportation

☐ Language barrier ☐ Provider supply ☐ None

11. Do you have a primary care doctor or healthcare provider? (A primary care doctor is a doctor who will see you for a checkup and sick visit.)

☐ Yes ☐ No Name of your doctor________________________

City ______________________________ State _______

12. If you are sick and need medical advice, where do you go?

☐ Doctor's office ☐ Clinic or health center

☐ Hospital outpatient department

☐ Hospital emergency department ☐ Urgent care center

☐ Some other kind of place ☐ Don't know/not sure

13. What type of assistance, if any, do you need in making or keeping medical appointments?

☐ Childcare/eldercare ☐ Transportation

☐ Language ☐ None

☐ Other, please describe ______________________________

Health Information

14. In the past 6 months, have you had any health problems?

☐ Yes Date___/___/___ Health problem ___________________

☐ No

15. Have you or any member of your immediate family had cancer? (Immediate family includes parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, and nephews.)

☐ Yes ☐ No (Skip to question 16)

If yes, please check all that apply.

	Name	Age at Diagnosis	Siblings/ Children	Age at Diagnosis	Mother's Side	Age at Diagnosis	Father's Side	Age at Diagnosis
For Example: Colorectal Cancer	You	36 yrs.	Brother	36 yrs.	Aunt Cousin	58 yrs. 44 yrs.	Grandmother	65 yrs.
Breast Cancer								
Cervical Cancer								
Ovarian Cancer								
Colorectal Cancer								
Prostate Cancer								
Other								

16. Currently, do you smoke cigarettes, cigars, pipes or use other tobacco products? (If yes, skip to question 18.)

☐ Yes ☐ No

17. Have you smoked cigarettes within the last 15 years? (If no, skip to question 22.)

☐ Yes ☐ No

18. Do you smoke cigarettes? (If no, skip to question 22.)

☐ Yes ☐ No

19. On average how many packs of cigarettes do/did you smoke per day? ______

20. How long have you been smoking cigarettes, or how long did you smoke cigarettes? ______

21. Have you had a CT scan of your lungs within the last 12 months?

☐ Yes ☐ No

22. Do you live in a house with a basement below ground level?

☐ Yes ☐ No

23. Has a doctor, nurse or other healthcare professional ever told you that you have diabetes?

☐ Yes ☐ Yes, but only when I was pregnant

☐ No, but told I have pre-diabetes

☐ No, but told I was borderline or had a touch of sugar

☐ No ☐ Don't know/not sure

24. Has a doctor, nurse or other healthcare professional ever told you that you have high blood pressure?

☐ Yes ☐ Yes, but only when I was pregnant

☐ No, but told I was pre-hypertensive or borderline high

☐ No ☐ Don't know/not sure

25. Has a doctor, nurse or other healthcare professional ever told you that your blood cholesterol is high?

☐ Yes

☐ No, but told I was borderline high

☐ No

☐ Don't know/not sure

26. Women only: Are you pregnant?

☐ Yes ☐ No

27. Women only: Do you plan to become pregnant in the next year?

☐ Yes ☐ No

28. Women only: Do you still have your cervix?

☐ Yes ☐ No

28a. If no, was it removed due to cervical cancer or pre-cervical cancer?

☐ Yes ☐ No

29. Do you have a disability?

☐ Yes ☐ No

Agreement and Authorization to Release Information

☐ I have provided and will continue to provide true and accurate information.

☐ I give my consent for you to access the state information system to determine my eligibility for medical assistance benefits, and I authorize you to give my medical and other information to others for the purpose of survey, study, or research as long as personal identifying information about me is not made public.

Client Signature: ____ Date __________________

For office use only:

Medicaid Inquiry Date: ____________________

Medicaid Application Status

☐ Medicaid pending

☐ Enrolled full Medicaid ☐ Enrolled limited Medicaid only

☐ Recently denied; denial date: _________________

☐ Not completed because non-citizen status

☐ Not completed because over income for Medicaid

☐ Not completed because, other: _________________