HealthyWoman Program (HWP) Enrollment Information

The following information will help determine if you are eligible for the Department of Health, HealthyWoman Program. It will also tell us how to improve the Program. Thank you for answering the following questions.

5. Were you diagnosed with breast or cervical cancer or pre-cancer prior to filling out this enrollment information?  **YES**  **NO**

6. Do you currently have health insurance?
   - No (Skip to question 7)
   - Yes, please answer the following questions:
     - The type of health insurance I have is:
       - 1. Medical Assistance/ACCESS
       - 2. adultBasic
       - 4. Private/Employer Sponsored Plan
       - Although I have insurance I need help paying for HWP services because:
         - My insurance does not cover screening services provided by the HWP.
         - I am unable to cover the co-pay or deductible required by my insurance.
         - I have met my benefit limits.

   If you checked box #4, Private/Employer Sponsored Plan, please complete the following:

<table>
<thead>
<tr>
<th>INSURANCE CARRIER NAME</th>
<th>POLICY NO.</th>
<th>GROUP NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   7. Is this your first visit in this program?  **YES**  **NO**  Tell us how you heard of the program. Is this your second year in the program or have you been a HWP client for some time?  **YES**  **NO**  Tell us how you knew to come back. (check one)

   - Friend, Relative
   - Physician
   - Outreach Worker
   - Healthcare Provider (other than a physician)
   - Reminder/Invitation from HWP
   - Church
   - Community Event
   - Other, please specify ________

   8. Are you Hispanic or Latina?
      - Yes (1)
      - No (2)

   9. What race do you consider yourself?  (May select more than one)
      - White (1)
      - Black or African American (2)
      - Asian (3)
      - Pacific Islander or Native Hawaiian (4)
      - American Indian or Alaska Native (5)
      - Other (6)

   10. What is your marital status?
       - Never married (1)
       - Married (2)
       - Widowed (3)
       - Divorced/Separated (4)
       - Other (5)

   11. What is the highest grade you completed in school?

   12. Are you a citizen of the United States or an alien in lawful immigration status?  **Yes**  **No**

   13. Are you a resident of Pennsylvania?  **Yes**  **No**

   14. May the Department of Health mail you information about women's health issues?  **Yes**  **No**

Please read and sign the other side of this form.
The Pennsylvania Department of Health (DOH) offers a health program for women called the HealthyWoman Program (HWP). This Program offers breast and cervical cancer screening. Screening can find cancer early so it can be treated or cured. The way to screen or test for breast cancer is to have a doctor or nurse examine your breasts and to have a breast X-ray, which is called a mamogram. The way to screen for cervical cancer is to have a pelvic exam and a Pap test. A Pap test is a smear taken from the cervix during the pelvic exam. The HWP pays for screening tests. If you are eligible for this Program, you should not be asked to pay for these tests.

If you have an abnormal screening test result, sometimes more tests are needed. The HealthyWoman provider will help you get the extra tests. The Program can pay for some of the extra tests needed. The provider will tell you if the Program will pay for a test that is recommended before you have the test. If needed, case management services will be offered to you.

If treatment for breast or cervical cancer is needed, the HealthyWoman provider will help you to get treatment. The Program does not pay for treatment. Medicaid may be available to pay for treatment.

### HealthyWoman Program Consent for Release of Information

I understand the explanation above about the Pennsylvania Department of Health, HWP for women. I agree to be screened by the HWP. I give permission to any and all of my healthcare providers to provide all personal and medical information to the DOH and its contractors involved in this Program, as necessary, to perform treatment, care, and healthcare operations. This includes information about screening and other test results, treatment, care, and information from this form. I give permission for the DOH to share information with my healthcare provider(s) as needed for treatment, payment, and healthcare operations. I understand that I can revoke this consent at any time, except to the extent that the DOH has already released information based on this consent. I may request further restrictions on the disclosure of my information.

I understand that any information I give to the DOH is confidential. This means the DOH will not disclose or share my information, except for the minimum necessary to administer the Program described above. Statistical reports which result from this Program will not use my name or any other identifying information.

By signing this form, I am stating that I agree to, and understand, the terms of the Program described above. I am also stating that the information I provided on the other side of this form is true. I understand that my participation in this Program is voluntary, and that I can drop out of the Program at any time.

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<table>
<thead>
<tr>
<th>Signature</th>
<th>Today's Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witness Signature</td>
<td>Today's Date</td>
</tr>
</tbody>
</table>

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### Medicaid Breast & Cervical Cancer Prevention & Treatment (BCCPT) Program

I understand that my diagnosis and other eligibility factors provide me the option to enroll in the Medicaid BCCPT Program. I decline to enroll in the BCCPT Program at this time. Please initial and date: ______________    _______________________

Please review and complete the following section only if you agree to proceed with enrollment in the Medicaid BCCPT Program.

### Medicaid BCCPT Program Rights and Responsibilities

- I understand that if I need treatment for breast or cervical cancer, the information on this form will be used to see if I am eligible for Medicaid.
- I understand that the information on this form will be kept confidential.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the Medicaid program.
- I understand that I must report any change in my circumstances that may affect my eligibility to the County Assistance Office within one week of the change.
- I understand that I may request a hearing if I do not agree with a decision made on this application.
- I understand that all Medicaid applicants/recipient must provide their Social Security Number, except those applying for treatment for an emergency medical condition. This number may be used to check the information on this application.
- I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when healthcare coverage may be denied or limited for a pre-existing condition. If I enroll in a group plan that allows for a pre-existing condition, I may get credit for the time I received Medicaid.
- I certify that the information on this application is correct under the penalty of perjury.
- I certify that I understand my rights and responsibilities.

Applicant’s Signature ___________________________________________ Date ____________________
Commonwealth of Pennsylvania – Department of Public Welfare

Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program
Medicaid Eligibility Application – Part B

Instructions for completing Form PA 600B – Part B

PART I – TO BE COMPLETED BY THE APPLICANT OR APPLICANT’S REPRESENTATIVE

The Applicant or Applicant’s representative should:

1. Print clearly or type the information in the spaces provided on the other side of this form.

2. Sign and date this form.

PART II – TO BE COMPLETED BY A PROVIDER

DATE OF DIAGNOSIS: Enter either the date of the first positive biopsy/confirmation of diagnosis, or the confirmation of reoccurrence of breast or cervical cancer.

ICD-9 CODE: Check the most appropriate box to indicate the diagnosis, and complete the diagnosis code to individually identify the condition. Only one box should be checked. If 196 or 198 is checked, the provider is attesting that the applicant has either breast or cervical cancer, including pre-cancerous conditions of the breast or cervix, as a primary diagnosis. If breast or cervical cancer, including pre-cancerous conditions of the breast or cervix, is not the primary diagnosis, applicant is not eligible for this program.

PROVIDER NAME: Enter the name of the provider who renders medical care to the applicant.

PROVIDER MPI/NPI NUMBER: If the provider is a Medical Assistance (MA) participating provider, enter the number assigned to the designated payee. If the provider is not an MA provider, leave the field blank.

TELEPHONE NUMBER: Enter the telephone number of the office where the applicant is seen.

ADDRESS - STREET, CITY, STATE: Enter the address of the office where the applicant is seen.

PROVIDER AUTHORIZED SIGNATURE AND DATE: Signature of the provider who renders medical care to the applicant and the date the form is completed. NOTE: This signature attests to the fact that all information indicated in Part II is complete and accurate.

The provider must fax or mail the application back to the Department of Health’s HealthyWoman Program Provider.

HWP Intake Site ___________________________ Fax Number ___________________________

HWP Intake Site Number ___________________________

PART III – TO BE COMPLETED BY THE COUNTY ASSISTANCE OFFICE
### Part I. To be completed by the applicant or applicant’s representative

<table>
<thead>
<tr>
<th>ICD.9 Code</th>
<th>Clinical Descriptor</th>
<th>Initial Eligibility Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>174.____</td>
<td>Malignant Neoplasm of Female Breast, Primary</td>
<td>12 month</td>
</tr>
<tr>
<td>174.0</td>
<td>Nipple and areola; 174.1 - Central Portion; 174.2 - Upper-inner quadrant; 174.3 - Lower-inner quadrant; 174.4 - Upper outer quadrant; 174.5 - Lower outer quadrant; 174.6 - Axillary tail; 174.8 - Other specified sites of female breast; 174.9 - Breast, unspecified.</td>
<td></td>
</tr>
<tr>
<td>196.____</td>
<td>Secondary and Specified/Unspecified Malignant Neoplasm of Lymph Nodes (with Breast Primary)</td>
<td>12 month</td>
</tr>
<tr>
<td>196.1</td>
<td>Infrathoracic lymph nodes (bronchopulmonary, mediastinal, intercostal, tracheobronchial); 196.3 - Lymph nodes of axilla and upper limb (brachial, infraclavicular, epitrochlear, pectoral); 196.8 - Lymph nodes of multiple sites</td>
<td></td>
</tr>
<tr>
<td>198.____</td>
<td>Secondary Malignant Neoplasm of Other Site (with Breast Primary)</td>
<td>12 month</td>
</tr>
<tr>
<td>198.2</td>
<td>Skin (skin of breast); 198.3 - Brain and spinal cord; 198.5 - Bone and bone marrow; 198.81 - Other specified sites (breast, excludes skin of breast); 198.89 - Other (with breast CA primary)</td>
<td></td>
</tr>
<tr>
<td>233.____</td>
<td>Carcinoma in Situ, Breast</td>
<td></td>
</tr>
<tr>
<td>233.0</td>
<td>Breast</td>
<td></td>
</tr>
</tbody>
</table>

### Part II. To be completed by a provider

**Provider Name**: [Confirming diagnosis]  
**Provider MPI/NPI Number**:  
** Telephone Number**: (____) 
**Address**:  
**State**:  
**Zip Code**:  

**Provider Authorized Signature**:  
**Date**:  

**Provider**: Please fax (____) or mail this application back to the Department of Health’s HealthyWoman Program Screening Contractor.

### Part III. To be completed by county assistance office

1. □ Applicant is eligible for ongoing Medicaid - beginning [
2. □ Applicant is not eligible for ongoing Medicaid

**Reason for Rejection**: □ No documentation of alien status

□ Other: ____________________________

**Cao Worker’s Signature**:  
**Date**:  

**County Number**:  
**Record Number**:  
**Category**:  
**Line No.**:  

---

**Part I. To be completed by the applicant or applicant’s representative**

<table>
<thead>
<tr>
<th>Applicant’s Name (Last, First, Middle Initial)</th>
<th>Birth Date</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthplace (State, County, City)</td>
<td>Name on Birth Certificate (Last, First, Middle)</td>
<td>Mother’s Maiden Name (Last, First, Middle)</td>
</tr>
<tr>
<td>Applicant’s Signature</td>
<td>Date</td>
<td>Driver’s License or ID (State/Number)</td>
</tr>
</tbody>
</table>

---

**Part II. To be completed by a provider**

**Date of First Biopsy/ Confirmatory Diagnosis**  
**Date of Confirmation of Recurrence of Breast or Cervical Cancer**

**ICD.9 Code**  
**Clinical Descriptor**  
**Initial Eligibility Timeframe**

**Part III. To be completed by county assistance office**

1. □ Applicant is eligible for ongoing Medicaid - beginning  
2. □ Applicant is not eligible for ongoing Medicaid

**Reason for Rejection**: □ No documentation of alien status

□ Other: ____________________________

**Cao Worker’s Signature**:  
**Date**:  

**County Number**:  
**Record Number**:  
**Category**:  
**Line No.**: 