CEED PROGRAM AT VIRTUA – INTAKE APPLICATION

Fill out information requested in area provided

NAME: _____ **E-mail:** _____

Date of Last: Mammogram_____ Pap Smear_____

FIT test (stool kit) _____ Rectal Exam_____ Colonoscopy/Sigmoidoscopy _____

How did you hear about our program?

Are you experiencing any of the following: a breast lump, nipple discharge, changes in your nipple, or other symptom of breast cancer?

If you answered yes, please call our office immediately at 856-247-7386 or 856-247-7385.

Have you been diagnosed with breast cancer?

Do you have a mother, sister, aunt, or grandmother who has been diagnosed with breast or ovarian cancer? If yes, please list the relative and age at diagnosis.

Have you had a history of any abnormal Pap smears in the past?

Are you having any cervical issues such as abnormal bleeding or vaginal discharge?

If you answered yes, please call our office at 856-247-7386 or 856-247-7385.

Have you been diagnosed with colon cancer, colon polyps, Lynch syndrome, IBS, or other colon problem?

Do you have a mother, father, sister or brother who has been diagnosed with colon cancer or precancerous polyps?

Are you experiencing rectal bleeding?

<u>Men Only</u>

Date of Last: Prostate Exam _____ PSA (blood test) _____

Have you been diagnosed with prostate cancer or have a brother, father or uncle who has been diagnosed

Form completed by: _____ Date: _____

NJCEED CONSENT TO PARTICIPATE AND RELEASE

I, _____ desire to have a:

__X__CLINICAL BREAST EXAM __X__MAMMOGRAM
__X__PELVIC EXAM (women only) __X__PAP TEST (women only)
__X__DIGITAL RECTAL EXAM __X__PSA (men only)
__X__OTHER _____OTHER-Transfer Pt. from another State_____
as part of the NJ Cancer Education and Early Detection Program (NJCEED) sponsored by NJDH&SS. The risks and benefits of these procedures have been explained and I consent to the performance of the examinations and tests. I understand that the examinations will be performed at no charge to me.

In consideration of the information contained in the previous paragraph, I hereby release __ VIRTUA __and the officers, directors, agents, contractors, and employees of this organization from any liability whatsoever arising out of the screening, including, but not limited to, performance of the examinations and tests, as well as any failure to correctly report the results of the tests and any failure to make correct recommendations. Any findings may be used to compile data for a program study with the understanding that my name will not appear in any publication of this data.

I understand that the findings and recommendations will be reported to me and I am responsible to follow those recommendations and for any expenses involved. I also understand that in addition to the tests performed today, other testing might be necessary to diagnose cancer.

I understand that although the procedures listed above are considered highly effective for the detection of cancer, no screening can be guaranteed to be 100% effective.

I understand that the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPPA" privacy notice) govern the terms of this authorization. I understand that I have the right to revoke this authorization, at any time prior to Virtua's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in Virtua's Notice of privacy practices.

Prostate Cancer Screening (men only): I understand that I am going to the doctor to discuss the need for prostate cancer screening with PSA and digital rectal exam. If, after that discussion I wish to move on to screening I understand the NJCEED Program will pay for my PSA at Virtua and digital rectal exam at the CEED doctor's office.

I have read this release and signed of my own free will, intending to be legally bound. Any questions that I have asked concerning this release have been answered to my satisfaction.
DATE: _____SIGNATURE:_____
WITNESS: _____

INFORMED REFUSAL

I have been informed of the clinical screening tests that are available at no charge and I have been informed about the NJCEED guidelines recommended for cancer screenings. I choose not to participate at this time.
DATE:_____SIGNATURE:_____
WITNESS:_____

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby give my permission to _____ to release a copy of my medical records and information to_____. This information is to be used for follow-up results of the tests I have had. The information may be used to compile data for a program study, but my name will not appear in any publication of this date. I understand that confidentiality of my medical information will be maintained.

I have read this release and signed of my own free will, intending to be legally bound. Any questions I have concerning this program have been answered to my satisfaction.

Signed: _____ Date: _____
Witness: _____ Date: _____

Patient Declaration of Income and Insurance

Do you have Health Insurance Coverage?

No_____ Yes_____ (Please Circle Type Below)

Medicare AmeriHealth

Medicaid Blue Cross/Blue Shield

Aetna Any type of Family Care

Other:_____

I,_____, confirm that **I do not** have health insurance coverage of any type at this time and that my ***annual income*** is _____.
This income supports_____people of these ages:_____.
Therefore, as a resident of New Jersey, according to the New Jersey Department of Health guidelines, I am eligible for cancer screenings under New Jersey Cancer Education and Early Detection (NJCEED) Program.

I attest that the information stated above is true and accurate and to the best of my knowledge. I understand that if the above information is misrepresented, it may be grounds for suspension of Program services and that I may be required to pay the total actual cost for the services provided to me under the NJCEED Program.

Signed_____ Date_____

Address_____

Phone Number_____

Witness_____ Date_____

Burlington and Camden County
NJCEED Program at Virtua
Virtua Health and Wellness Center
200 Bowman Drive
Suite D-290
Voorhees, NJ 08043

Burlington and Camden County Cancer Education and Early Detection Program

Thank you for your interest in the New Jersey Cancer Education and Early Detection (NJCEED) Program.

In order to be eligible for this program you must qualify in **EACH** of the following three areas:

(1) Age/risk factor**, AND**
(2) Income (<250% of Federal Poverty Level), **AND**
(3) No insurance or underinsured

How to apply for our program:

1. Attached are four documents:
   - Data Collection Form
   - NJCEED Consent to Participate and Release
   - Patient Declaration of Income and Insurance
   - Intake Application
2. Please print, complete, sign and date all documents
3. Please mail all four completed and signed documents to:

   NJCEED Program at Virtua
   Health and Wellness Center
   200 Bowman Drive Suite D-290
   Voorhees, NJ 08043

A staff member will call when we receive the application to inform you of your eligibility.

If you have any additional questions about the NJCEED Program, please call (856) 247-7388 during normal business hours.

Sincerely,

Jackie Miller, RN
NJCEED Program Manager

CaST Data Collection Form

Patient Information:

Social Security _____

Last Name:_____ First Name:_____

Middle Initial:_____ Maiden Name:_____

Address Information:

Primary Address:_____

City:_____ County:_____

State:_____ Zip Code:_____

Day Phone: ( )_____

Race:
American Indian__ Asian__ Black__ Eskimo__
Native Hawaiian__ Other__ Unknown__ White__

Ethnicity:
Hispanic__ Non-Hispanic__

Place of Birth City:_____ State:_____ Country:_____

Gender: Female_____ Male_____ Other_____

Sexual
Orientation: Heterosexual_____ Lesbian_____ Gay_____ Bisexual_____

Smoking Status:
Current Smoker___ Never smoked___ Former Smoker (1+ year)___
Former Smoker (within last year)_____
Quit line Referral: Yes_____ No_____ Date:____/_____/_____

Name of Primary Physician:_____ Phone Number:_____

Emergency Contact Information:

Name and Relationship_____

Day Phone: ( )_____

Financial Responsibility

Number supported by this income?_____ Annual Household Income (before taxes): $_____

Available Health Insurance – NEW JERSEY IS THE PAYER OF LAST RESORT (check all that apply):

Medicare___ Medicaid___ None___ Blue Cross/Shield___ HMO___ Other___

Policy #:_____