Delaware Screening for Life Program – Enrollment Form

Client ID Number: __ __ __ __ __

MCI # (future use):________________ Initials of person completing form __ __ __

Gender: ❑ M ❑ F **Last Name:** ______________________ **First Name:** ______________________ **MI:** ______

Maiden Name: ______________________ SSN: __ __ __ - __ __ - __ __ __ __ Date of Birth: ___/___/_____ (mm/dd/yyyy)

Street Address:____

City:______________________ State: __________ Zip: ______________ County:______________________

Day Phone: (__ __ __) - __ __ __ - __ __ __ __ Evening Phone (__ __ __) - __ __ __ - __ __ __ __ Today's Date: ___/___/___

How did you hear about the Screening for Life Program? (Check all that apply)

❑ Outreach ❑ Provider ❑ Other (Please specify) ______________________________

Client Eligibility

1. What kind of health insurance do you have? (all that apply)

- ❑ Medicare
- ❑ Medicaid
- ❑ Other (specify)______________________
- ❑ None (skip to question #4)

2. This year, does your insurance pay for:

- Pap smears? ❑ Yes ❑ No
- Mammograms ❑ Yes ❑ No
- Colorectal exams? ❑ Yes ❑ No

3. Have you met your deductible?

- ❑ Yes
- ❑ No
- ❑ Does not apply

4. How many people are in your household?_____________

5. What income, if any, do you and anyone else in the household receive? (for example: SS disability, pension, trusts, child support, alimony, unemployment, workers comp. benefits, etc.)

$____________ per ❑ Week ❑ Month ❑ Year

6. In the past 6 months, has a doctor told you that something might be wrong with your breasts?

- ❑ **Yes Date** __/_____ (mm/yyyyy)
- ❑ No

7. What type of assistance, if any, do you need in making or keeping your medical appointment?

❑ Transportation ❑ Childcare/Eldercare
❑ Disability ❑ Language

Describe ______________________________

Background

8. Are you of Hispanic or Latino origin, such as Puerto Rican, Mexican American, Latin American or Cuban?

- ❑ Yes
- ❑ No
- ❑ Unknown

9. What race to you consider yourself? (check all that apply)

❑ White ❑ Black/African American
❑ Asian ❑ Native Hawaiian or other Pacific Islander
❑ American Indian or Alaskan Native
❑ Unknown ❑ Other

10. Are you a current smoker?

- ❑ Yes
- ❑ No

11. What is the highest level of education you have completed?

- ❑ Less than high school
- ❑ Some high school
- ❑ High school graduate
- ❑ More than high school

12. Do you have a primary health care provider?

- ❑ Yes
- ❑ No

If yes, name of Provider:______________________________

City______________________ State____________

13. Have you or has any member of your immediate family had cancer?

- ❑ Yes
- ❑ No

If yes, what kind? (check all that apply)

❑ Bladder ❑ Larynx ❑ Oral cavity
❑ Brain ❑ Leukemia ❑ Ovary
❑ Breast ❑ Liver ❑ Pancreas
❑ Cervix ❑ Lung ❑ Prostate
❑ Colorectal ❑ Leukemia ❑ Stomach
❑ Esophagus ❑ Lymphoma ❑ Thyroid
❑ Hodgkin's disease ❑ Melonoma ❑ Uterus
❑ Kidney ❑ Myeloma ❑ Other

CLIENT SCREENING FORM INFORMATION (as of 1-1-03)

General Info

The Screening for Life Program (SFL) requires screening/diagnostic results be reported on all breast and cervical screenings and diagnostics prior to any payment to healthcare providers. Results are reported on a client screening form (CSF). and. if appropriate, a diagnostics form. Forms are to be completed by the in-network primary care provider/physician. The screening cycles may vary for each client; e.g., three months, six months, or yearly (routine) depending on medical recommendations.

Screening Cycles

A new form is required for each screening cycle. While a follow-up, visit for further diagnostic evaluation is NOT considered a new screening cycle, a "short-term" follow-up IS considered a new screening cycle and requires a new client screening form. For example, a repeat CBE, a biopsy, or an ultrasound are considered diagnostic extensions of a screening cycle. In contrast, a rerun visit, 3-months after a "probably benign" mammogram, is considered a new screening cycle and requires a CSF.

About the Client Screening Form (CSF)

The client screening form has a pre-printed 6-digit number (colored ink), in the upper right hand comer. This number should not be confused with the 5-digit client ID number. If a screening requires a diagnostic evaluation the CSF form number is copied to the diagnostics form.

Complete the top section using information provided on the insurance card or directly from the client. Test results are required for all services provided as part of a screening and/or diagnostic work-up. When absolutely necessary, use the "Unknown" options. Be sure to check the appropriate boxes and list the date of service.

Diagnostic Forms

Diagnostic evaluations/tests are to be recorded on diagnostic forms. These forms are completed by the in-network PCP or diagnostic surgeon/specialist. It is critical that the CSF number is referenced on the diagnostics form. If you are having trouble identifying the CSF number, call the SFL office (302-744-1040). Multiple visits/tests within the same screening cycle should be reported on a single diagnostics form. Please ensure that the diagnostic forms are complete (site number, test result and date for each service. If a test is inconclusive/indeterminate, please comment on further evaluation and list the results as pending.

Invoices for Services Provided

All invoicing must be provided on the HCFA-1500 or the UB92 insurance forms. The required information includes Client ID #, Client Name, Date(s) of Service, CPT Code(s), Amount Charged, Amount Received from Other Sources (if any), Site Number, and Patient Account #. While not required on invoices, providing the CSF# on your invoices will help to ensure that they are linked properly to the appropriate screening data forms.

Site Numbers

Every participating provider is assigned a "site number'. It is critical that the appropriate site numbers are used when completing data forms (screening site, mammogram site ...) and invoices for services. If you have questions regarding your site number or the number of another provider of services (e.g. mammogram provider or lab), refer to the provider-training packet or call the SFL office at (302-744-1040). It is imperative that you provide your site number (or write out the name of your facility) at the top of all data forms. Without this number, there is no way to connect a data form to the provider that sent it.

Submitting Data Forms and Invoices

The top (white) copy of the screening and diagnostic forms, and invoices, are to be mailed to:

Screening for Life
Thomas Collins Building, Suite 11
540 South duPont Highway
Dover, DE 19901
(Retain the pink copy for your records)