screening for Life

Health Care Connection

Client ID #: ______________________ Today's Date: __________________

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

- SFL offers breast, prostate, cervical, colorectal, and lung cancer screenings.
- HCC is a referral service that helps that helps you find a doctor who will see you at 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* (SFL) and/ or the *Health Care Connection* (HCC) programs?

☐ Newspaper ☐ TV ☐ Internet ☐ Radio ☐ Billboard ☐ Direct mail to residence ☐ Clinic/Health Center/Doctor's Office ☐ Hospital ☐ Word of Mouth
☐ Pamphlet/Brochure ☐ Help Line ☐ Other, please specify: ______________________

Last Name: ______________________ First Name: ______________________ MI: ________

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

Home Address: ______________________ Apt: ________ P.O. Box: ________

City: ______________________ State: ____________ Zip Code: ____________ County: ______________

Mailing Address (if different from above): ______________________

Daytime Phone: ________________ Other Phone: ________________ Email address: ______________________

Date of Birth: ________________ Sex: ☐ Male ☐ Female Social Security number: ______________________

Race (mark all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

Are you of Hispanic/Latino origin? ☐ Yes ☐ No 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 ☐ Post high school education

Household Members: Tell us who is in family. A household consist of you (the client), your spouse, and any children 18 years of age and younger within your legal guardianship, including unborn children. **Number of people in your household:** __________.

Complete the following based on the number of people in your household. Do not include yourself in this table.
(For additional members, please use a separate sheet of paper.)

Last Name	First Name	MI	Date of Birth	How is this person related to you?

Client Eligibility

2. What Kind of health care coverage do you have? (Check all that apply.)
☐ Medicare (Please circle coverage type below.)
Part A Part B SLMB QMB
☐ Medicaid ☐ Private Insurance (HMO, PPO, etc.)
☐ Military Benefits ☐ None (Skip to Question 6)
☐ Other (Please specify.) ____________________

3. This year, your health care coverage pays for:
☐ Pap Smears ☐ Prostate Screenings
☐Mammograms ☐ Lung Cancer Screenings
☐ Colorectal Exams

4. Have you met your deductive?
☐ Yes (Specify amount of deductible.) $ __________
☐ No (Specify amount of deductible.) $ __________
☐ Do not apply

5. Have there been any changes in your health care coverage in the past 6 months?
☐ Yes ☐ No

6. How long has it been since you had health care coverage?
☐ 0 to 6 months ago ☐ 6 to 12 months ago
☐ 1 to 2 years ago ☐ 5 or more years ago
☐ Don't know / Not Sure ☐ Never

7. What is the main reason you are without health care coverage?
☐ Lost job or changed employers
☐ Employer does not offer or stopped offering coverage
☐ Could not afford to pay premium
☐ Lost Medicaid or medical assistance
☐ Other (Please specify.) ____________________
☐ Don't know / Not sure

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

9. Indicate your current situation (check all that apply):
☐ Employed for wages ☐ Student
☐ Receiving alimony ☐ Retired
☐ Receiving workers' compensation ☐ Receiving child support
☐ Unable to work ☐ Receiving unemployment
☐ Receiving SSI/SDD ☐ 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 ☐ 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 or need medical advice, where do you go?

☐ A doctor's office ☐ Clinic or health center
☐ Hospital outpatient department ☐ Urgent care center
☐ Hospital emergency department ☐ Don't know / Not sure

13. What types 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 had cancer?

☐ Yes, Type of Cancer: ________________________________
Age at diagnosis: ____________
☐ No

16. Has a member of your immediate family been diagnosed with cancer? (Immediate family includes parents, children, siblings, grandparents, aunts, uncles, nieces, and nephews.)

☐ Yes (Complete chart below) ☐ No

Type of Cancer	Relation	Mother's or Father's Side	Age of Diagnosis

17. Currently, do you smoke cigarettes, cigars, pipes or use other tobacco products? (If no, skip to question 19.)

☐ Yes
☐ Quit (1 to 12 months ago)
☐ Quit (more than 12 months ago)
☐ Never smoked

18. Have you smoked cigarettes in the last 15 years? (If no, skip to question 23)

☐ Yes ☐ No

19. Do you smoke cigarettes? (If no, skip to question 23.)

☐ Yes ☐ No

20. On average, how many packs of cigarettes do/did you smoke per day? __________

21. How long have you been smoking cigarettes, or how long did you smoke cigarettes? __________

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

☐ Yes ☐ No

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

☐ Yes ☐ No

24. Has a doctor, nurse, or other health care professional ever told you that you have diabetes?

☐ Yes
☐ Yes, but only when I was pregnant
☐ No, but I was told I have pre-diabetes
☐ No, but I was told I was borderline or had a touch of sugar diabetes
☐ No ☐ Don't know / Not sure

25. Has a doctor, nurse, or other health care professional ever told you that you have high blood pressure?

☐ Yes
☐ Yes, but only when I was pregnant
☐ No, but I was told I was pre-hypertensive or borderline high
☐ No ☐ Don't know / Not sure

26. Has a doctor, nurse, or other health care professional ever told you that your blood cholesterol is high?

☐ Yes
☐ No, but I was told I was borderline high
☐ No
☐ Don't know / Not sure

27. Women only: Are you pregnant?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

29a. If no, was it removed due to cervical cancer or pre-cervical cancer?

☐ Yes ☐ No

30. 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 to share and discuss my information with my health care provider(s) to ensure that I receive the appropriate screenings and/or follow-up care. 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.

☐ I give my consent for you to contact me to discuss barriers to care so that referral options and patient navigation services can be discussed and provided to clients are both agreeable and eligible to receive these services.

Client's signature: ____ Date: ____________________

For SFL / HCC office use only:

Screening for Life
☐ **Enrolled**
☐ **Ineligible**

Health Care Connection
☐ **Enrolled**
☐ **Ineligible**

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

screening for life

Health Care Connection

Application Addendum
Screening for Life and Health Care Connection Programs

The below questions are a part of the SFL application. All responses are MANDATORY before any application can be processed in entirety.

Please Note: Responses are only used for eligibility and determination of benefits. The responses below will not impact eligibility into the SFL program. Eligibility is based on income and other risk factors.

31. Are you a U.S. Citizen?
☐ Yes
☐ No

31a. If **NO**, do you have legal documentation to reside in the United States?
☐ Yes
☐ No

32. Have you ever served in the United States Armed Forces (Navy, Air Force, etc.)?
☐ Yes
☐ No

33. **WOMEN ONLY:** If you are pregnant, planning to become pregnant in the next year, and/or have children five years of age or younger, would you like a referral to the Maternal Child Health Bureau to be contacted about programs you may be eligible for?
☐ Yes
☐ No

34. If **YES** was selected for question number ***17***, would you like to be referred to the DE Quit Line?
☐ Yes
☐ No

35. If **YES** was selected for question number ***23***, would you like to be referred to the DE Healthy Homes?
☐ Yes
☐ No

36. In the past 90 days, have you experienced a lack of food for yourself and your family?
☐ Yes
☐ No

36a. If **YES** was selected for question number ***7***, would you like to be referred to free resources for food?
☐ Yes
☐ No

37. Is lack of daytime transportation a barrier to attending your cancer screening appointments?
☐ Yes
☐ No

38. Do you have children in your home?
☐ Yes
☐ No

38a. If **YES**, do you have appropriate childcare available to attend your medical appointments?
☐ Yes
☐ No

38b. If **NO,** would you like to be referred to resources for childcare assistance?
☐ Yes
☐ No

39. Do you have adequate access to home cleaning supplies?
☐ Yes
☐ No

39a. If **NO,** would you like to be referred to free resources for cleaning supplies?
☐ Yes
☐ No

40. Do you take any medications?
☐ Yes
☐ No