Client ID #: _____ **Today's Date:** _____

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

- *Screening for Life* offers breast, prostate, cervical, colorectal, and lung cancer screenings.
- *Health Care Connection* is a referral service that helps that helps you find a doctor who will see you at lower cost.
- **THESE PROGRAMS ARE NOT INSURANCE**

For additional information about SFL and HCC, please call **2-1-1** (toll-free) or the SFL/HCC office at **(302) 744-1040 (Mon. – Fri. , 8:00 AM to 4:30 PM).**

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:** _____

Middle Initial (MI): _____ **Maiden Name:** _____

Please list any other names (alias) that you may have used: _____

What is your housing situation today? ☐ I have housing ☐ I have housing, but I am worried about losing my housing ☐ I do not have housing

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____ - _____ **County:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____ - _____ **County:** _____

Daytime Phone: _____ **Other Phone:** _____ **Email:** _____

Would you like to receive emails from our programs? ☐ Yes ☐ No

Date of Birth: _____ **Sex:** ☐ Male ☐ Female **Social Security #:** _____ **Primary Language:** _____

Have you ever served in the United States Armed Forces? ☐ Yes ☐ No

Are you a U.S Citizen? ☐ Yes ☐ No **If not a U.S. Citizen, do you have legal documentation?** ☐ Yes ☐ No

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

Are you of Hispanic/Latino origin? ☐ Yes ☐ No **Do you identify as Haitian?** ☐ Yes ☐ No

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. Per Program Policy, a household consist of you (the client), your spouse (if married), and any children under the age of 18 years of age within your legal guardianship, including unborn children. Those that do not meet this description should not be included in this application.

Number of people in your household, including yourself: _____.

List the members of the household below. Do not include yourself in this table. (For additional members, please use a separate sheet of paper.)

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

If you have a child that is under 6 years of age, would you like to be referred to the Maternal Child Health Program for additional resources? ☐ Yes ☐ No

Client Eligibility

2. What kind of health care coverage do you have? (Check all that apply.)

☐ Medicare (Check all that apply)
☐ Part A ☐ Part B ☐ Part C ☐ Part D
☐ Medicaid
☐ Full ☐ Limited/Emergency
☐ Military Benefits ☐ Private Insurance (HMO, PPO, etc.)
☐ None (Skip to Question 6)

3. This year, does your health care pay for (check all that apply):

☐ 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 (Specify the changes.) _____
☐ 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. If you are 18 years or older, please answer A, B, and C. If you are under 18 years old, please answer D and E.

a. What is your income before deductions (gross income)?
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
Amount (please specify.) $ _____

b. Is your spouse (if married) employed?
☐ Yes (answer 8c.) ☐ No (skip to question 9)

c. What is your spouse's (if married) income before deductions (gross income)?
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
Amount (please specify.) $ _____

d. What is your parent's (if you are under the age of 18 years old) income before deductions (gross income)?
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
Amount (please specify.) $ _____

e. What is your second parent's (if you are under the age of 18 years old) income before deductions (gross income)?
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
Amount (please specify.) $ _____

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

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, Name of your Doctor: _____
Name of Healthcare Facility: _____
City: _____ State: _____
☐ No

12. If you are sick or need medical advice, where do you go?
☐ A doctor's office
☐ Hospital outpatient department
☐ Hospital emergency department
☐ Clinic or health center
☐ Urgent care center
☐ Don't know / Not sure

13. What types of assistance, if any, do you need in making or keeping medical appointments?
☐ Childcare / Eldercare
☐ Language
☐ Other (please specify.): _____
☐ Transportation
☐ None

Health Information

14. In the past 6 months, have you had any health problems?
☐ Yes (list them below) ☐ No

Health Problem	Onset Date

15. Have you or any member of your family had cancer?
☐ Yes (Complete chart below) ☐ No

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

16. Currently, do you smoke cigarettes, cigars, pipes or use other tobacco products?
☐ Yes
☐ Quit (1 to 12 months ago)
☐ Quit (more than 12 months ago)
☐ Never smoked

a. If you answered yes to Question 16, would you like to be referred to the Delaware Quit Line?
☐ Yes ☐ No

17. Have you smoked cigarettes in the last 15 years?
☐ Yes ☐ No

18. Do you smoke cigarettes?
☐ Yes ☐ No

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

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

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

a. If you answered yes to Question 22, would you like to be referred to the Delaware Healthy Homes?
☐ Yes ☐ No

23. 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

24. 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

25. Has a doctor, nurse, or other health care professional ever told you that you have high blood pressure?
☐ Yes
☐ No, but I was 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

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

29. Do you have a disability?
☐ Yes ☐ No

30. **In the past 90 days have you experienced lack of food for yourself and your family?**
☐ Yes ☐ No
   a. **If you answered yes to Question 30, would you like to be referred o free resources for food?**
   ☐ Yes ☐ No
31. **Is lack of daytime transportation a barrier to attending your cancer screening appointments?**
☐ Yes ☐ No
32. **Do you have children in your home?**
☐ Yes ☐ No
   a. **If yes – Do you have appropriate childcare available to attend your medical appointments?**
   ☐ Yes ☐ No
   b. **If no – Would you like to be referred to resources for childcare assistance?**
   ☐ Yes ☐ No
33. **Do you have adequate access to home cleaning supplies?**
☐ Yes ☐ No
   a. **If no – Would you like to be referred to free resources for cleaning supplies?**
   ☐ Yes ☐ No
34. **Women Only: Have you ever received a pelvic exam?**
☐ Yes ☐ No
   a. **If yes: What was the date of your most recent pelvic exam (MM/YYYY):** _____
35. **Women Only: Have you ever received a Pap test?**
☐ Yes ☐ No
   a. **If yes: What was the date of your most recent Pap test (MM/YYYY):** _____
36. **Women Only: Have you ever received a HPV test?**
☐ Yes ☐ No
   a. **If yes: What was the date of your most recent Pap test (MM/YYYY):** _____
37. **Women Only: Have you ever received a mammogram?**
☐ Yes ☐ No
   a. **If yes: What was the date of your most recent mammogram (MM/YYYY):** _____
38. **Do you use any of the following types of computer: Desktop/Laptop, Smartphone, Tablet?**
☐ Yes ☐ No
39. **Do you or any member of this household have access to the internet?**
☐ Yes – by paying a cell phone company or internet service provider
☐ Yes – without paying a cell phone company or internet service provider
☐ No
40. **For HCC Applicants, are you currently taking any medications?**
☐ Yes (Please provide more information about the medication taken in the space below)
☐ 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