



STEPHENSON COUNTY HEALTH DEPARTMENT
 10 W. Linden Street, Freeport, IL 61032-3310
 (815) 235-8271 FAX: (815) 232-7160



AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION UNDER HIPAA

I, _____, hereby authorize _____
 (Name of Patient or Personal Representative)

Well Woman Medical Providers to release the information listed below to:

Well Woman of NWIL - Stephenson County Health Department
 (Name of Person to Receive Information)

10 W. Linden Street, Freeport IL 61032
 (Street Address) (City) (State) (Zip)

from the designated record of _____ whose birth date is _____
 (Patient's Name)

and whose address is _____

The following information shall be released (mark all applicable):

- Entire Medical Record, Except for Records concerning Mental Health Treatment, Alcohol, or Other Drug Treatment, HIV/AIDS Information, and Genetic Information.
- Mental Health Treatment Records
- Alcohol or Other Drug Treatment Records
- HIV/AIDS Records
- Genetic Information
- Laboratory Reports
- X-Ray or Other Photographic Reports
- Immunization Records
- Breast or Cervical Cancer, Cardiovascular, or Osteoporosis Screening Records
- Other: _____

The purpose of the authorization is:

- At the Request of the Individual or Personal Representative
- Other: _____

The information should be released for the following time period: from _____ to _____
 (Start Date) (End Date)

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information on reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that the health department may not condition treatment, payment, or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

This authorization for release of protected health information terminates on: _____
 (Date)

Signature: _____ Date: _____

If you are the personal representative of the patient, please specify your relationship to the patient: _____

**ILLINOIS BREAST AND CERVICAL CANCER PROGRAM
CLIENT PARTICIPATION AGREEMENT & RELEASE OF INFORMATION**

I. PROGRAM DESCRIPTION: The Illinois Breast & Cervical Cancer Program (Program) is a cooperative effort between the Illinois Department of Public Health, Office of Women's Health and the U.S. Centers for Disease Control & Prevention (CDC). The Program encourages routine breast and cervical cancer screening and provides free screening and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screening is to detect cancer, if present, at an early stage so it can be treated or cured. Screening for breast cancer involves a clinical breast examination and a mammogram (a breast x-ray). Screening for cervical cancer involves a pelvic examination and a Pap test (scraping from the cervix).

II. CONSENT TO PARTICIPATE & RELEASE OF INFORMATION: I understand and agree to the following:

- I will provide proof of age and income to determine Program eligibility. If I have insurance coverage, I will provide a copy of my insurance card and written verification of covered services.
- I give permission to my healthcare provider(s), hospital, clinic, laboratory and/or mammography facility to provide information concerning my breast and cervical cancer screening, diagnostic examinations and/or treatment status to Program staff.
- I understand that the Program must obtain certain statistical information for reports, including but not limited to age, income, insurance and any services I am provided through this Program. This information may be used by the Program and the CDC to learn more about breast and cervical cancer and to ensure the quality of services provided through the Program. **My name will not be used in these reports, except as required by law.**
- My healthcare provider and/or the Program staff will try to contact me regarding my test results. I understand that, despite efforts to find me, my health is my own responsibility and I may need to contact my provider for my test results.
- I understand that if the provider orders tests not covered by the Program that I may be responsible for payment of those services as the Program cannot pay for some diagnostic exams. A list of allowable services is available upon request.
- If I am diagnosed with a pre-cancerous or cancerous condition of my breasts or cervix, information from my IBCCP file will be released to the Illinois Department of Healthcare and Family Services. This information will be used to determine if I am eligible for state paid health benefits through Medicaid.
- If I am not eligible for Medicaid coverage, the Program staff will assist with securing payment for treatment services through private sources, community based sources, other governmental grants or pro bono from a provider.
- If I am eligible for state paid health benefits through Medicaid, I give my permission for Program staff to obtain information about my treatment for breast or cervical cancer. This information will be used to determine my treatment status and my continued enrollment in Medicaid.
- I have received literature and/or education on all of the following: breast self-exam, mammograms, and Pap tests.
- I will receive notification from the Program staff to remind me when it is time for me to go back to my medical provider for my annual examination and follow-up testing, if appropriate.
- I will notify the Program of any change in my address and/or telephone number.
- I will write or call the local Program staff to inform them if I no longer wish to be a part of this program. This notification will be recorded in my Program records.
- I understand the importance of keeping all appointments made for me so my care can be provided in a timely manner. When it is necessary to cancel or change an appointment, I will notify the agency of this change.
- Missed appointments or repeated "no show" appointments are not acceptable and I can potentially lose my ability to receive screening if this happens.

Client Signature _____ **Date** _____

Illinois Breast and Cervical Cancer Program
Health Assessment

Name: _____

Date: _____

Breast Health Questions

YES NO

- 1. Do you perform a monthly breast self-exam?
- 2. Have you noticed a lump in your breast?
If yes, which breast? _____
- 3. Have you noticed any breast tenderness or pain?
If yes, which breast? _____
- 4. Have you noticed any discharge from your nipples?
If yes, which breast? _____
- 5. Have you noticed any other symptoms related to your breasts?
If yes, explain: _____
- 6. Have you ever had a clinical breast exam done by a doctor or nurse?
7. If yes, date of last two exams: ____/____/____, ____/____/____
- 8. Have you ever had a mammogram?
9. If yes, date of last two mammograms: ____/____/____, ____/____/____
Name of Hospital: _____
- 10. Have you ever had breast cancer?
If yes, which breast? _____
If yes, lumpectomy or mastectomy? (please circle)
- 11. Has your mother, sister or daughter had breast cancer? If no, got to question 14.
12. If yes, who? _____
13. If yes, at what age? _____ years old
- 14. Do you have a breast implant or implants?
- 15. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
If yes, which breast? _____

Cervical Health Questions

YES NO

- 16. Have you ever had a Pap smear?
17. If yes, date of last two Pap smears: ____/____/____, ____/____/____
- 18. What was the date of your last menstrual period? ____/____/____
- 19. Have you had a hysterectomy?
- 20. Was your hysterectomy due to a past history of cervical disease or cervical cancer?

**Illinois Breast and Cervical Cancer Program
Eligibility Determination Form**

<input type="checkbox"/> New Client Registration Date: _____	<input type="checkbox"/> Established Client Annual Verification Date: _____	Cornerstone # (Office Use Only): _____
Name: _____ Day Phone: _____ Maiden Name: _____ Night Phone: _____ Address: _____ Age: _____ Birth Date: ____/____/____ City: _____ Social Security #: _____-____-____ State: _____ Zip Code: _____ Alternate Contact: _____ County: _____ Day Phone: _____		
Income Eligibility: If single - total income before taxes or if married - total combined income before taxes: \$ _____ per month/year (circle one) Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: _____ Office Use Only: Income status for number in household: At or below 250% of poverty federal level: <input type="checkbox"/> Yes <input type="checkbox"/> No Above 250% of federal poverty level: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical/Insurance Coverage: Check all that apply. Medicare Part B – Not eligible for IBCCP <input type="checkbox"/> I have NO insurance <input type="checkbox"/> Medicaid ID number _____ <input type="checkbox"/> Insurance? Name of Carrier: _____ Does insurance pay for: Pap tests? <input type="checkbox"/> No <input type="checkbox"/> Yes Mammograms? <input type="checkbox"/> No <input type="checkbox"/> Yes Please provide a copy of the front and back of your insurance card.		
Marital Status/Relationship: <input type="checkbox"/> Never Married (01) <input type="checkbox"/> Married (02) <input type="checkbox"/> Widowed (03) <input type="checkbox"/> Divorced (04) <input type="checkbox"/> Separated (05) <input type="checkbox"/> Unknown (09) <input type="checkbox"/> Other _____	Years of Education Completed: <input type="checkbox"/> _____ (EO # of years) <input type="checkbox"/> None (E000) <input type="checkbox"/> Unknown (E099)	Employment Status: <input type="checkbox"/> Employed full-time (35+ hours weekly) (EFT) <input type="checkbox"/> Seasonal/Migrant Farm Worker (SMF) <input type="checkbox"/> Employed part-time (EPT) <input type="checkbox"/> Unemployed (UNE)
Are you of Hispanic origin? <input type="checkbox"/> Yes (01) <input type="checkbox"/> No (00) What races do you consider yourself? Mark ALL that apply. <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islanders <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Unknown		How did you hear about this program? <input type="checkbox"/> Poster, Flier, Brochure (B) <input type="checkbox"/> Case Management Outreach (C) <input type="checkbox"/> Community Event (CE) <input type="checkbox"/> State Promotional Campaign (ST) <input type="checkbox"/> Physician or Health Care Provider (P) <input type="checkbox"/> Newspaper, Radio, Television (ME) <input type="checkbox"/> Other (OTH), Specify: _____
Re-screen Clients: Have you noticed: <input type="checkbox"/> a breast lump, <input type="checkbox"/> any breast tenderness or pain, <input type="checkbox"/> discharge from your nipples, or <input type="checkbox"/> any other problems with your breasts? <input type="checkbox"/> N/A (Please check all that apply.) Please explain any problems: _____ Are you having abnormal vaginal bleeding or other concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: _____ When was your last menstrual period? ____/____/____		
What is the best time to schedule your appointments? (Please circle your choices.) Day of the week: Monday Tuesday Wednesday Thursday Friday Time of day: Early morning Mid morning Early afternoon Late afternoon Preferred Healthcare Provider: _____		
I understand that if I have given false information or intentionally failed to disclose information for this application, I may be subject to criminal prosecution, civil action or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge. Applicant's Signature _____ Date _____		

Please complete this page in full.

CORNERSTONE INFORMED CONSENT FORM

Name of Participant: _____
(Last) (First) (M)

Date of Birth: _____ Male _____ Female _____
(Month) (Day) (Year)

Participant's ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; and Healthy Families Illinois.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Departments of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client's name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

Stephenson County Health Department

- A. I authorize Well Woman of NW Illinois (Cornerstone site) to collect information during the enrollment/registration process.
- B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal, birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program, and Early Intervention. Any information you do not want released should be written in Part D.
- C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.
- D. The following information I do NOT want to be shared:
- E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Departments of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.
- F. A photostatic copy/facsimile of this consent will be as valid as the original

For child participant:

For adult participant:

Signature of parent/legal guardian/caretaker/Date

OR

Signature of adult participant/Date

Signature of Witness: _____

Date: _____

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH
BREAST AND CERVICAL CANCER PROGRAM**

REQUIRED VERIFICATION

You **must** include the following verification with your enrollment/re-enrollment packet in order for your paperwork to be processed. If the information highlighted is not returned, we will send it back to you for completion, before we can schedule your appointments.

- **Age Verification (copy of your driver's license, ID card or birth certificate)**

Medicaid Verification

If you have Medicaid, you are not eligible for IBCCP. If you are on a spend-down, you may still qualify for the Program. Please include the amount of any spend-down payment that is required to be paid by you

Amount of spend-down \$ _____

If you have a Medicaid card, do not complete the forms and call Holly at 815/599-8420 or toll free at 1-866-590-8499.

Insurance Verification

If you have private insurance and it will cover any of the charges for your exams (regardless of the deductible) you do not qualify for the program. Please call Holly at 815/599-8420 or toll free at 1-866-590-8499, to let her know you will not be enrolling / re-enrolling in the Program.

If your insurance does not cover your annual exams and screenings (even if you would meet your deductible), you must have your insurance company submit documentation that they will not pay in order to qualify for the Program.

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH
BREAST AND CERVICAL CANCER PROGRAM**

REQUIRED VERIFICATION

You **must** include the following verification with your enrollment/re-enrollment packet in order for your paperwork to be processed. If the information highlighted is not returned, we will send it back to you for completion, before we can schedule your appointment

▪ **Income Verification - for you & spouse, if married**

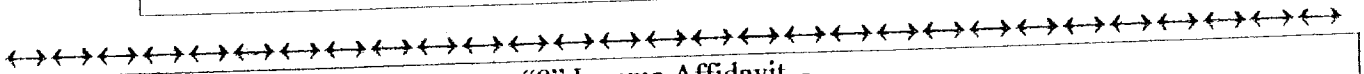
Include copies of **one** of the following:

- Current year tax form
- Current W2
- Current two paycheck stubs
- Social Security/Disability
- Retirement/Pension

Illinois Breast and Cervical Cancer Program (IBCCP)
Income Eligibility Guidelines
(July 1, 2008 – June 30, 2009)

List the number of people in your household: _____
Count yourself, spouse, and any children **18** years old and younger
(Please do not include any other family members age 19 and older)

Household Size	Less than:	Household Size	Less than:
1	\$26,000	5	\$62,000
2	\$35,000	6	\$71,000
3	\$44,000	7	\$80,000
4	\$53,000	8	\$89,000



“0” Income Affidavit -

(Please complete this box only if you and your spouse (if married) have \$0 income.)

I, _____ reside at _____
And attest to the fact that I have received \$ _____ income for the period covering
_____ to _____. I met my financial obligations during this period by:
(How did you pay for: rent/mortgage, utilities, and any other bills?)

I understand that to perjure myself in order to obtain assistance is a fraudulent offense for which I can be prosecuted.

Signature _____ Date _____

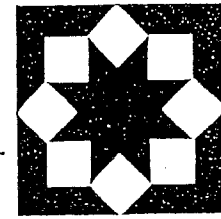
Witnessed by _____ Date _____

STEPHENSON COUNTY HEALTH DEPARTMENT

Building a Healthy Community

www.co.stephenson.il.us/health

CRAIG BEINTEMA, MS, LEHP
Public Health Administrator



10 W. Linden Street
Freeport, IL 61032-3310
(815) 235-8271
FAX: (815) 232-7160

**CONSENT and ACKNOWLEDGMENT
Receipt of Joint Notice of Privacy Practices**

I, _____ do hereby consent to allow the Stephenson County
(print name of client)

Health Department and its designated employees and contractors to provide medical, health, dental, and/or social services to me (example: perform a medical evaluation and treat conditions found therein). I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the health department dated April 14, 2003.

Signed

Date

Check if any of the following apply:

- Parent or Guardian of minor
- Power of Attorney for Health Care
- Guardian with power to make health care decisions
- Health Care Surrogate
- Mental Health Treatment Preference Declaration Agent

FOR STAFF USE ONLY:

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the health department. The health department was unable to obtain the Acknowledgment because:

- Client refuses to sign
- Other (specify): _____

_____ (Staff member's initials)

_____ (Date)

(Staff: Place Acknowledgment in patient's medical record.)

Illinois Breast and Cervical Cancer Program
Well Woman of Northwest Illinois

Does the candidate fit the IBCCP (Illinois Breast and Cervical Cancer Program) guidelines?

- Lives in Illinois
(Well Woman of NW IL serves women in Stephenson, JoDaviess, Carroll, Ogle & Lee Counties)
- Age 35-64 for clinical breast exam (CBE) & Pap test; Age 40-64 for CBE/Pap test & mammogram
- Uninsured or Underinsured (Insurance does not cover Pap smear/Mammogram) (No Medicaid)
- Symptomatic women; breast or cervical, will be served on a priority basis
- Younger, symptomatic women who meet the guidelines are considered on a case by case basis
- A woman diagnosed by a medical provider and found to have breast or cervical cancer or a precancerous cervical condition – age 19-64 – US resident – no form of insurance to pay for treatment services

Please refer to IBCCP / Well Woman program:

Name: _____ Date of Birth: _____

Address: _____

Phone #: _____

Mail to: Well Woman of Northwest Illinois
Stephenson County Health Department
10 West Linden Street
Freeport, IL 61032

Fax to: 815-599-8405
/or/ 815-232-7160

**Questions? Please call the Well Woman office -
Holly at 815-599-8420, Emily at 815-599-8434
Or toll free at 1-866-590-8499**

Statement of consent:

I hereby authorize release of my name, address, phone number and date of birth to IBCCP / Well Woman of Northwest Illinois Program, whose representative may contact me.

Signature _____ Date _____