Montana Cancer Screening Program

1035 1st Ave W. Kalispell, MT 59901
Phone: (406)751-8162 or (406)751-8163
Fax: (406)751-8161 and (844)870-0231

Last Name	First Name	Middle Initial	Other Names Used
Date of Birth		Social Security Number	
Mailing Address	City	State	Zip
Home Phone ( ) -	Cell Phone ( ) -	Email Address	

Ethnic Background

Are you Hispanic? (Spanish/Hispanic/Latino?

□ Yes □ No

Race (Please check all races that apply)

□White □ American Indian or Alaska Native □Black or African American
□Asian □Native Hawaiian or Pacific Islander □Unknown

Eligibility Information	Family's yearly income before taxes?	Number of people in household?

Do you have Medicare? □Yes □No Do you have Medicaid? □Yes □No Do you have health insurance? □Yes □No

If Yes, Name of Insurance Company	Deductible Amount?

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Center for Disease Control and Prevention (CDC) to provide breast and cervical cancer screening services for age and income eligible women. Each time a woman is screened for breast cancer, she may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, she may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered

The MCCP only provides services for breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

Insurance Information

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Patient Navigation Services

I understand if I enrolled for patient navigation services only, MCCP is not financially responsible for any medical expenses incurred by me while enrolled for patient navigation services only.

Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), and/or Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask questions about the MCCP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out of the MCCP at any time.

Client Signature: _____ Date: _____/_____/_____

Print Full Name: _____