



Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

The Annual Applicant Agreement (AAA) is used to obtain authorization and information from eligible women enrolled in the Florida Breast and Cervical Cancer Early Detection Program (FBCC). The FBCC will collect participant Protected Health Information (PHI) and Personally Identifiable Information (PII) that is required to provide patient services.

Please read each statement below and agree by signing at the bottom of the document.

As an FBCC applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCC, and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level (FPL) and I have no health insurance that pays for breast and cervical cancer screening exams.
3. I will no longer be eligible for FBCC if my income changes to above 200% of the FPL.
4. I will call FBCC Once I obtain health insurance and give them the name of the health insurance company, policy number and effective date. If my health insurance covers breast and cervical cancer screenings my screenings will no longer be paid for by FBCC.
5. I will disclose any breast or cervical screening services that may impact my eligibility of enrollment in FBCC.
6. I may have a share of cost for some services.
7. I will use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test).
8. **I agree to complete any follow-up tests within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.**
9. I will allow an exchange and release of my medical information between my health care providers, the FBCC, the Florida Department of Health's Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination and procedure results, even if they were not paid by FBCC.
10. I agree to receive home phone, cellphone, email or postal mail contact from FBCC and the Department of Children and Families (DCF) Medicaid Program about my health care.
11. I understand that the FBCC is a breast and cervical cancer **screening** program, not a cancer treatment program.
12. If I am diagnosed with breast or cervical cancer as a result of FBCC screening, I will be referred to DCF Medicaid Program which will determine if I am eligible for Medicaid benefits to cover treatment cost. I can reapply to FBCC for screenings once treatment is completed.
13. This agreement is for **one** year unless my program eligibility changes. If my eligibility status changes or this agreement expires, I may be responsible for services provided during my FBCC ineligible period.
14. **As authorized by federal law, Title 5 U.S. Code section 552a, collection of social security numbers by the Florida Department of Health for the FBCC may be necessary in order to apply for and receive Medicaid benefits.**

If you have any questions, contact your Regional Coordinator at the local Regional FBCC office:

Local Regional FBCC: _____ Phone _____

Client Signature

Date

Printed Name

Date of Birth

Client Email Address: _____



Florida Breast and Cervical Cancer Early Detection Program (FBCC)

FINANCIAL ELIGIBILITY

Client Name: _____ **Date of Birth:** _____ **ID#** _____

1. Do you have Medicaid? YES NO **OR** Do you have Medicare? YES NO
2. Do you have any form of health insurance? YES NO Name of insurance _____
3. **Number of people in your Household.** _____ (include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes):** \$ _____ Month **OR** \$ _____ Year

Family Size	2026 DOH Scale Monthly Income	2026 DOH Scale Yearly Income
1	\$2,659.91	\$31,919.00
2	\$3,606.58	\$43,279.00
3	\$4,553.25	\$54,639.00
4	\$5,499.91	\$65,999.00
5	\$6,446.58	\$77,359.00
6	\$7,393.25	\$88,719.00
7	\$8,339.91	\$100,079.00
8	\$9,286.58	\$111,439.00
9	\$10,233.25	\$122,799.00
10	\$11,179.91	\$134,159.00

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:

If I obtain health insurance coverage, while under the FBCC, it is my responsibility to notify the REGIONAL FBCC office as soon as possible.

Signature _____

Date _____

If you have any questions, please call the regional coordinator at _____ (727) 619-0369 _____ between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.



Florida Breast and Cervical Cancer Early Detection Program Client Enrollment Form

LAST NAME:	<input type="text"/>	FIRST NAME:	<input type="text"/>	MAIDEN NAME:	<input type="text"/>	DATE OF BIRTH:	<input type="text"/>
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1. APPLICANT INFORMATION (Please complete each section of this application.)

CONTACT INFORMATION

STREET ADDRESS:

STREET ADDRESS:

CITY & ZIP CODE:

EMAIL ADDRESS:

PRIMARY PHONE:

ALTERNATE PHONE:

BEST TIME TO REACH YOU:

A.M. P.M. Anytime

Is it okay to leave a message?

PREFERRED APPT. DAY/TIME:

HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)

American Cancer Society Postcard

Brochure Television

County Health Department Radio

Community/Health Fair event Social Media

Family/Friend Educational Session

Internet/Website Bus wraps/benches/signs

Private Medical Office Billboards

Newspaper Name of Community Health Clinic:

Federally Qualified Health Center

Other

SCREENING STATUS (Check only one response.)

Initial (first time in program) Rescreen (previously in program)

Short-term interval follow-up or repeat exam (less than 300 days from last screening)

Do you have health insurance? Yes No

If yes, what is the name of your insurance?

DEMOGRAPHIC INFORMATION

RESIDENTIAL AND CITIZENSHIP STATUS (Check all that apply.)

Florida resident U.S. Citizen Citizen in lawful status Other

ETHNICITY AND RACE IDENTIFICATION (Check all that apply.)

Hispanic/Latino Non-Hispanic/Latino

RACIAL IDENTITY

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

SPOKEN LANGUAGE(S)

Primary language spoken:

Additional language(s) spoken:

Language preference to receive email:

English Spanish Haitian Creole

BARRIERS

Are there any barriers that would prevent you from keeping your appointments?

Transportation Language Disabilities

Other (List)

FOR OFFICE USE ONLY
Client Assigned ID#: <input type="text"/>



Florida Breast and Cervical Cancer Early Detection Program Client Enrollment Form

LAST NAME:	<input type="text"/>	FIRST NAME:	<input type="text"/>	MAIDEN NAME:	<input type="text"/>	DATE OF BIRTH:	<input type="text"/>
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2. HEALTH HISTORY

GENERAL HEALTH STATUS (Check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pre-Diabetes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol

HEIGHT (in.): WEIGHT (lbs.):

BREAST EXAM BACKGROUND (Check all that apply)

Do you have breast implants?

Are you currently experiencing any issues with your breasts? Explain.

Have you ever been diagnosed with breast cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last mammogram before enrolling in this program? (Month/Year)

None Unsure (2+ years)

Where was your last mammogram done? (Provider, City, State)

FAMILY HISTORY

Has anyone in your family, such as your mother, sister, brother, or father, been diagnosed with breast cancer? If yes, which relative?

TOBACCO USE (includes vaping, e-cigarettes, and similar products) (Check all that apply)

<input type="checkbox"/> Daily	<input type="checkbox"/> Were you given a referral to Quitline?
<input type="checkbox"/> Some days	<input type="checkbox"/> Declined referral
<input type="checkbox"/> Never/not at all	<input type="checkbox"/> I am interested in quitting.
<input type="checkbox"/> Declined to answer	

CERVICAL EXAM BACKGROUND (Check all that apply)

Are you currently experiencing any issues with your cervix? Explain.

Have you ever been told by a doctor you have invasive cervical cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last Pap test before enrolling in this program? (Month/Year)

None Unsure (10+ years)

Where was your last Pap test done? (Provider, City, State)

Have you ever had a hysterectomy? Specify whether partial or full.

Partial hysterectomy (I still have a cervix) Full hysterectomy (no cervix)

What was the reason for the hysterectomy?

FOR OFFICE USE ONLY

Client Assigned ID#:



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Florida Department of Health- FBCC & Premier Community Healthcare

Phone #: (727) 619-0369

Address: 11611 Denton Avenue Hudson, FL 34667-5420

Fax #: (727) 861-4805

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: State of Florida and Centers for Disease Control & Prevention

Phone #: (850) 245-4444

Fax #: (850) 922-9321

METHOD OF DISCLOSURE:

Pick up at Clinic/Facility

Address: _____

Fax #: _____

Email Address: _____

(Please note that emailing may not be a secured method of communication)

INFORMATION TO BE DISCLOSED: (Initial Selection)

General Medical Record(s), including STD and TB Progress Notes History and Physical Results

Immunizations Family Planning Prenatal Records Consultations

Diagnostic Test Reports (Specify Type of test (s)) _____

Other: (Specify): FBCC imaging and reports, visit notes

I Specifically authorize release of information relating to: (Initial Section)

HIV test results for non-treatment purposes Substance Abuse Service Provider Client Records

Psychiatric, Psychological or Psychotherapeutic notes Early Intervention WIC

PURPOSE OF DISCLOSURE:

Continuity of Care Personal Use Other (specify) Case management, data collection, epidemiology

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize the treatment will not be denied if I refuse to sign this form.

REVOCAATION: I understand that I have the right to revoke this authorization anytime. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

Client/Legal Representative Signature

Date

Printed Name

Legal Representative's Relationship to Client

Witness (optional)

Date

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example, power of attorney, healthcare surrogate form, order or appointment of a guardianship, order appointing personal representative and letters of administration).

Client Name: _____

ID#: _____

DOB: _____

Original: To File Copy to Client