Montgomery County Department of Health and Human Services

CANCER PREVENTION AND TOBACCO PROGRAM

COLORECTAL CANCER SCREENING APPLICATION

The Montgomery County Cancer Prevention and Tobacco Program provides screenings for colorectal cancer at no cost to eligible residents. For assistance, please call (240)777-1750.

In addition to the application, the following information is needed for the applicant:

You must provide ALL the checked items to process your application. If you should have any difficulty obtaining such information, please notify the program so we may assist you. Incomplete applications will not be processed, and you will be determined ineligible.

- ❑ Proof of residency:
  Only one of the following, in your name:
  - Current lease
  - Mortgage
  - Utility bill
- ❑ Proof of earned income (total family income):
  Only one of the following:
  - Most recent year's taxes
  - Most recent W-2 statement
  - Two most recent pay stubs
  - Notarized letter from the applicant stating that the applicant is not working and does not have income
- ❑ Photo identification:
  Only one of the following:
  - MD driver's license
  - MD identification card
  - Permanent resident card (Green Card), passport, work authorization card
- ❑ Healthcare Facility/Provider:
  - Clinic/progress notes (most recent)

Submit the completed, signed application and other required documentation to:

Mail: Cancer Prevention and Tobacco Program
1401 Rockville Pike 4th floor, Suite 4100
Rockville, MD 20852
Fax: (240) 777-4819 Email: mocowccp@montgomerycountymd.gov

Please allow 7 – 10 business days for application review and medical approval.

Montgomery County Cancer Prevention and Tobacco Program Application

(Revised: 07/01/2023)

I'm interested in: ☐Colorectal Screening ☐Colorectal Patient Navigation

Patient Information:

Last Name:________________________________ **First Name:**_______________________ **Middle Initial**: ____

Date of Birth____/____/____ **Age**_____________ **Social Security Number:** ___________________________

Street Address:____ **Apartment/Room/Unit#:**___________

City___________________________ **County:**_________________________ **State**_______ **Zip code:** ___________

Telephone: Home (_____)______-__________ **Work** (_____)______-________ **Cell** (_____)______-_____________

Best number to call (_____)______-__________ **Text**: ☐Yes ☐No **Number:** (___)______-____________

Email Address: ____

Gender: ☐Male ☐Female **Ethnicity**: ☐Black Latina/Hispanic ☐White Latina/Hispanic ☐non-Hispanic

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Hawaiian/Other Pacific Islander ☐White/Caucasian ☐Other, specify____________________________

Highest Education level: ☐No high school ☐Some high school ☐High School graduate ☐Greater than high school ☐Unknown

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Separated ☐Never married ☐Partner of an unmarried couple

If married, spouse's full name____

Primary/preferred language: ☐English ☐Spanish ☐French ☐Chinese ☐Other, specify________________

Country of Birth:_________________ **Will you need an interpreter?** ☐No ☐Yes, in what language:______________

Do you have any needs or disabilities of which we should be aware? ☐No ☐Yes, check all that apply
☐Need help making appointments ☐Transportation ☐Hearing impairment ☐Speech Impairment ☐Learning Disability ☐Physical Disability ☐Handicap Access ☐Childcare/Elder care ☐Other, Specify_________________

Emergency Contact Information (person to contact if we cannot reach you)

Last Name________________________ First Name______________ Relationship to you: ________________________

Telephone: Home (_____)______-__________ Work (_____)______-________ Cell_ (_____)______-________________

Montgomery County Cancer Prevention and Tobacco Program Application

Household Information

Number of persons in household:________________________(including self, your spouse and any dependents)

Annual Income: $_________________(Income includes: employment, social security, disability, unemployment, investment income, etc. If you are married, you must include your husband's salary.)

If no income, explain how you are supported: ____

Health Care Provider/Doctor/Clinic and Health Insurance Information

Do you have a health care provider/doctor/Clinic: ☐No ☐Unknown ☐Yes

If yes, Health Care provider/Doctor/Clinic name:____

Where/Location: ____

Are you covered by health insurance: ☐No ☐Unknown ☐Yes

If yes, type of health insurance:____

If yes, you must attach a copy of the front and back of your insurance card to this form.

How did you learn of this screening program? (check all that apply)

☐Community Event ☐Other Healthcare Provider/Doctor ☐Friend ☐Family ☐Church ☐Brochure

☐ ☐Social Media ☐Poster ☐Internet ☐Radio ☐Other Local Program: _______________________

☐Other, specify: ____

Have you ever been screened or treated for colon, oral, skin, prostate, breast or cervical cancer by any Maryland Public Health Program? ☐No ☐Unknown

☐Yes, specify county(s):____

Personal Medical, Surgical, and Cancer History

Do you have or ever had any of the following illnesses/conditions: (check all that apply)

Allergies: ☐Yes ☐No ☐Unknown

High blood sugar: ☐Yes ☐No ☐Unknown

High blood pressure ☐Yes ☐No ☐Unknown

Other illness/conditions: ☐Yes ☐No ☐Unknown

If yes, kind/type of illness/condition:_______________

Medications: (list any you currently taking)

______________________ ______________________

______________________ ______________________

Any kind/type of surgery: ☐Yes ☐No ☐Unknown

If yes, kind/type of surgery:________________________

Date of Surgery_________________________________

Any kind/type of cancer: ☐Yes ☐No ☐Unknown

If yes, kind/type of cancer:_________________________

Date of diagnosis: _______________________________

Do you currently use tobacco? ☐Yes ☐No ☐Unknown

If yes, check all products used:

☐Cigarette ☐Pipe ☐Cigar ☐Split tobacco (snuff, chewing)

Have you smoked 100 or more cigarettes in a lifetime?

☐Yes ☐ No ☐Unknown

Montgomery County Cancer Prevention and Tobacco Program Application

Personal Medical, Surgical, and Cancer History Continued

Do you have or ever had any of the following illnesses/conditions: (check all that apply)

Colorectal Cancer: ☐Yes ☐No ☐Unknown If yes, date of diagnosis: ____________________

Colorectal Polyp: ☐Yes ☐No ☐Unknown If yes, date of first diagnosis: ____________________

Do you have any of the following symptoms:

Lower abdominal pain: ☐Yes ☐No   Marked change in bowel habits: ☐Yes ☐No

Unexplained weight loss: ☐Yes ☐No   Other gastrointestinal symptoms:____________

Bright red blood per rectum, bloody stools: ☐Yes ☐No

Have you been previously screened for colorectal cancer? ☐Yes (check all that apply) ☐No ☐Unknown

☐Sigmoidoscopy Date______________ Where______________ Results______________

☐Colonoscopy Date______________ Where______________ Results______________

☐Barium Enema Date______________ Where______________ Results______________

☐FOBT/FIT Date______________ Where______________ Results______________

Other Test (specify):_Date______________ Where______________ Results______________

Appointment Information: The best days and times for your appointment (check all that apply)

Monday: ☐AM ☐PM   Tuesday: ☐AM ☐PM   Wednesday: ☐AM ☐PM

Thursday: ☐AM ☐PM   Friday: ☐AM ☐PM

Comments: ____

Signature Required by Applicant:

My signature below affirms that the information provided here is true to the best of my knowledge. I understand that knowingly providing false information may result in my discharge from the program.

Signature:______________________________ **Date:**______________________

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Use a separate form for each individual, program, organization or facility with which information may be shared.
Please type or print as clearly and completely as possible.

1 Patient name ______________________________ **Date of Birth** ______________

2 I hereby authorize and request the following party to ⬜ **release** ⬜ **receive information**

____
Name of individual, program, organization or facility

____
address

3 ⬜ **to** ⬜ **from the following party** ______________________________
Name of individual, program, organization or facility

____
address

4 The following information (INITIAL all items covered by this authorization):

_____ **Acknowledgment of receipt of services**

_____ **Complete program record (includes all items below):**

_____ Intake assessment _____ Treatment plan _____ Progress notes _____ Diagnosis

_____ History/Physical _____ Lab Results _____ Service/discharge summary

_____ Medications _____ Immunizations _____ Identifying Information

_____ Billing Records _____ Photographs, Video, Digital or other images

_____ Mental health _____ Records from other providers contained in the program record

_____ **Other (specify)** ______________________________

____

_____ **Alcohol or other drug treatment records (requires specific authorization). Specify below.**

_____ Complete record _____ Assessment results/history _____ Treatment/service plan progress/compliance

_____ Other (specify) ______________________________

5 The disclosure is for the following purpose(s) (Check all that apply):

⬜ Patient request ⬜ Treatment/continued care ⬜ Review current care

⬜ Payment ⬜ Insurance application ⬜ Legal

⬜ Other (please explain) ______________________________

____

6 **This authorization expires one year from the date the form is signed unless I indicate an earlier date or event *(must occur sooner than 1 year from the date of my signature)* here:**

Until Date: ______________________ **OR** Until specific event: ___________________________________

7 **I understand the following:**

a. By signing this form, I am authorizing that the health information specified in Section 4 be shared between the party named in section 2 and the party named in section 3.

b. I may revoke this authorization at any time by writing to the individual(s), program(s), organization(s) or facility/facilities authorized to release information. If more than one individual, program, organization or facility has been authorized to release information, a written revocation request must be submitted to each party.

c. If an individual, program, organization or facility has already released health information based on this authorization, revoking it will only prevent future disclosure by the party to whom a written revocation has been submitted.

d. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization, unless authorization is required to determine eligibility for services/benefits.

e. The information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.

8 **Patient Signature** ____ **Date** ____________________

Parent or Personal Representative Signature *(if applicable)* ______________________________ **Date** ____________________

If signed by Parent or Personal Representative, please indicate Relationship to Patient

⬜ Parent of Minor Child ⬜ Guardian ⬜ Authorized Representative

⬜ Other____

NOTICE

Any individual, program, organization or facility receiving information pursuant to this release is prohibited from redisclosing the information without the express, written consent of the patient. The information disclosed may be used only for the purpose(s) stated above.

If the information disclosed pursuant to this authorization contains information pertaining to alcohol or drug abuse treatment, diagnosis of alcohol or drug abuse or any referral for treatment of alcohol or drug abuse, 42 CFR Part 2 prohibits the unauthorized disclosure of these records.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records.

MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
Cancer Prevention and Tobacco Program
Colorectal Screening Client Consent Form

The Montgomery County Cancer Prevention and Tobacco Education Program is funded through the Maryland Department of Health (MDH) Center for Cancer Prevention & Control and/or the Centers for Disease Control and Prevention (CDC).

Printed Name:__________________________ Date of Birth: (MM/DD/YYYY)____/____/_______

I acknowledge that the Montgomery County Cancer Prevention and Tobacco Education Program has provided information to me about cancer screening.

PROVISION OF SERVICES

I consent to have the Montgomery County Cancer Prevention and Tobacco Education Program:

- Help me access cancer screening and follow-up, case management and/or patient navigation services for:

Mark "Yes" or "No" below:

Colorectal cancer __Yes __No

I understand that the Montgomery County Cancer Prevention and Tobacco Education Program may not be able to find a cancer even if I have one. If I need more tests or treatment that are not covered, I understand that the Montgomery County Cancer Prevention and Tobacco Education Program will also help direct me to other programs such as the Maryland Medical Assistance Program, the Maryland Health Benefit Exchange and other programs that may be able to pay for all or part of additional tests or treatment costs. Doctors or hospitals may bill me for services if other payment cannot be found. [I understand that the Montgomery County Cancer Prevention and Tobacco Education Program will pay for treatment services if I am eligible and to the extent of available funds.]

MEDICAL RECORDS RELEASE AUTHORIZATION

I consent to have the Montgomery County Cancer Prevention and Tobacco Education Program:

- Get my medical information;
- Release my medical information; and
- Help assess services received.

I authorize doctors and other medical providers (including hospitals and laboratories) to give the results of my examination(s), laboratory test(s), biopsy(ies), procedure(s) and/or hospital stay(s) related to cancer screening, diagnosis and treatment to the Montgomery County Cancer Prevention and Tobacco Education Program. I also authorize doctors and other medical providers to provide this information to the Montgomery County Cancer Prevention and Tobacco Education Program until it is determined that the screening, diagnostic work-up and initiation of treatment (or cycle of services) has been completed even if I become eligible for the Maryland Medical Assistance Program or other health insurance and the Montgomery County Cancer Prevention and Tobacco Education Program ceases paying for these services. I further authorize doctors and other medical providers to give information from my medical history about **past** cancer screenings, diagnoses, and treatment results to the Montgomery County Cancer Prevention and Tobacco Education Program.

I also authorize the Montgomery County Cancer Prevention and Tobacco Education Program to share my information with the MDH, the MDH data contractor and other MDH-sponsored cancer programs for quality

assurance, quality control and other program management purposes. I also authorize the Montgomery County Cancer Prevention and Tobacco Education Program to share my information without my name or address with the CDC and its data contractor if my services are funded by the CDC. I understand that all information given to the Montgomery County Cancer Prevention and Tobacco Education Program, MDH and/or the CDC is to help me get good medical care including:

- Making sure I get the right cancer screening, diagnosis and treatment services;
- Checking on the services I get; and
- Using data about my screening and treatment to manage and evaluate the program.

I also understand that for me to get the best medical screening and health care, the Montgomery County Cancer Prevention and Tobacco Education Program may need to give my records to my private doctor or to another doctor or medical provider, or to another MDH-sponsored cancer program in Maryland if I ask for services in another jurisdiction. By signing this consent form, I give my consent for this information to be provided as stated in this paragraph.

I understand that if I am part of the Montgomery County Cancer Prevention and Tobacco Education Program it does not mean that the Montgomery County Cancer Prevention and Tobacco Education Program is going to be my primary doctor or health care provider. Except for the release of information that I have authorized in this consent form, all information given to the Montgomery County Cancer Prevention and Tobacco Education Program, to MDH and its data contractor, to the CDC and their data contractors or to other MDH-sponsored cancer programs will be kept confidential and will not be disclosed again to others except as allowed or required by Maryland or Federal law.

I know that I can ask for a copy of my records. I agree that this consent for obtaining and sharing medical records will be in effect as long as I am enrolled in the Montgomery County Cancer Prevention and Tobacco Education Program or for a period of one year, whichever is shorter. I can take back the consent at any time by writing to the Montgomery County Cancer Prevention and Tobacco Education Program. I know that the information provided under this consent will be kept in a file for at least 10 years for the uses described in this consent.

ENROLLMENT

I understand that to administer the Program effectively, including making sure that services are provided to the right individual, the Montgomery County Cancer Prevention and Tobacco Education Program may ask me for my social security number (SSN). The Montgomery County Cancer Prevention and Tobacco Education Program uses my SSN: (1) as an identifier to make sure that the medical records from or to a doctor, laboratory, or hospital are really mine; and (2) to check whether or not I am enrolled in the Maryland Medical Assistance Program, so that money is not spent on someone who is ineligible for the Montgomery County Cancer Prevention and Tobacco Education Program. I understand that I do *not* have to provide my SSN, and if I do not provide it, I can still get services under the Montgomery County Cancer Prevention and Tobacco Education Program as long as I meet the Montgomery County Cancer Prevention and Tobacco Education Program eligibility requirements.

I am aware that if there is any change in my household income, my health insurance benefits, and/or my address, I must notify the Montgomery County Cancer Prevention and Tobacco Education Program immediately. **Failure to notify the Montgomery County Cancer Prevention and Tobacco Education Program about change in my household income, my health insurance benefits, and/or my address may result in my disenrollment from the program and being responsible for paying for services.**

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read the following informed consent:

a. I understand that COVID-19 testing may be required 3 – 4 days before my surgical procedure.
b. I authorize my test results to be disclosed to the Montgomery County Cancer and Tobacco Program for my colonoscopy to be performed.
c. I understand that if I test positive my colonoscopy will be rescheduled, and I will self-isolate according to the Centers for Disease Control and Prevention guidelines.
d. I understand that receiving this test does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree and will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

Printed Name: ______________________________ Date of Birth: (MM/DD/YYYY)___/____/____

Client Signature: ___________________________ Date:____/____/____

Witness Signature:___________________________Date:_____/____/____

CLIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Department's *Notice of Privacy Practices*:

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Client **Date of Birth** **Signature of Client/Parent/Guardian** **Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the department may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the DHHS will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Name	Relationship	Address, or DOB, or Telephone #

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the DHHS make all

Home Telephone Number:

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back numbers only

Written Communication Address:

- ☐ OK to mail to address listed above
- ☐ E-mail me at:

Mobile/Cell Telephone Number:

- ☐ OK to Text message with detailed information
- ☐ Leave message with call back numbers only

Fax Communication:

- ☐ OK to Fax at the number listed above
- ☐ E-mail me at:

Work Telephone Number:

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back numbers only

Other:

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Department.

2. These Authorizations may be revoked at any time by notifying the Department in writing at the Departments mailing address marked to the attention of "HIPAA Privacy Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

______________________________ ______________________________

Name of Client (Printed) Signature of Client

WHY SHOULD YOU USE THE MARYLAND TOBACCO QUITLINE, 1-800-QUIT-NOW?

IT'S FREE.
IT'S CONFIDENTIAL.
IT WORKS.

- All services and materials provided by the Quitline are FREE.
- We respect your privacy and won't judge you. Many of our Quit Coaches™ have used tobacco themselves. We are here to support your choice to live healthier.
- We can help you quit any kind of tobacco use- cigarettes, cigars, or smokeless. We can even give you information to help someone you care about to quit.
- We're here whenever you need us. A real person will always answer the phone.
- We really can help you. People who call us are more successful in quitting.

OUR QUIT COACHES CAN HELP YOU ON YOUR PATH TO A HEALTHIER, TOBACCO-FREE LIFE TODAY!

CALL
the Maryland Tobacco Quitline today.

GET HELP
you need to make a change.

24 hours a day. 7 days a week.

QUIT NOW
and start enjoying a healthier you.

Maryland's 1-800 QUIT NOW

SmokingStopsHere.com

1-800-QUIT-NOW
1-800-784-8669
TTY: 1-877-777-6534

Servicios tambien en Espanol
(Services also available in Spanish)

Maryland's 1-800 QUIT NOW

SmokingStopsHere.com

YOU CAN QUIT

MARYLAND TOBACCO QUITLINE

MARYLAND TOBACCO QUITLINE: A FREE PROGRAM TO HELP MARYLANDERS QUIT TOBACCO USE...

...FOR GOOD!

The Maryland Tobacco Quitline will help you:

- Find out about the benefits of quitting.
- Set a quit date and make a plan Just for you.
- Stick to your plan by giving you tips to help with cravings.
- Learn more about medicines that can help you quit.
- find local classes or other support.

When you sign-up, you can schedule times that are good for you to talk with a Quit Coach™.

"WE QUIT, SO CAN YOU!"

VISIT WWW.SMOKINGSTOPSHERE.COM TO HEAR OUR STORIES.

FREE WAYS TO HELP YOU QUIT

Call 1-800-784-8669 to talk to a live Quit Coach™ 24/7! Counseling is provided in English, Spanish, and other languages.

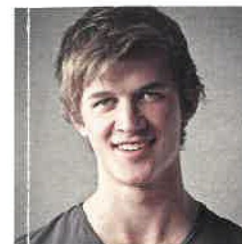
Go to www.SmokingStopshere.com to learn more. Click on the "ENROLL ONLINE NOW" button for our Web Coach™ program and find online tools and support from our Quit Coaches™.*

Text *Support* - When you use our phone or online programs, you can also sign-up to receive text messages to provide you with extra support, encouragement, and tips.*

Mail - We will send guides with helpful advice for you or someone you care about who is trying to quit.

And More - While supplies last, we may be able to send the nicotine patch or gum directly to your home!*

*Services available for Marylanders 18 years and older



ARE YOU 13-17 YEARS OLD?

FREE Services are available by calling 1-800-QUIT-NOW.

- Our Youth Quit Coaches™ will help you make a plan to quit and stay tobacco-free.
- All calls are private. If you'd like, guides to help you quit can be sent to you.

PREGNANT?

We will help you quit while you're pregnant and stay tobacco-free after your baby is born.

- Our free program includes counseling with our Quit Coaches™, mailed guides: and online* and text support.*

WE KNOW THAT QUITTING ISN'T EASY. HELP IS JUST A CALL OR CLICK AWAY. CHOOSE A COMBINATION OF SERVICES THAT WORKS BEST FOR YOU.