Michigan Colorectal Cancer Early Detection Program (MCRCEDP) Enrollment Form

MBCIS # _____

Enrollment Site or Clinic Name: _____ Date: _____

Client Contact Information – Please PRINT						**Are you a BCCCNP Client?** ❑ Yes ❑ No
Last Name		**First Name**		M.I.		
Social Security #		**Gender**	❑ Female ❑ Male			
Maiden Name		**Birth Date**				
Street Address		Apt		City		
PO Box		**State**		Zip Code		
County		Addl. Address				
Phone Number ( ) -		Ext		☐ Day ☐ Evening ☐ Home ☐ Work ☐ Fax ☐ Cell ☐ Pager		
Alt Phone # ( ) -		Ext		☐ Day ☐ Evening ☐ Home ☐ Work ☐ Fax ☐ Cell ☐ Pager		
Email Address (if available):						

Race and Ethnicity

Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Unspecified

Ethnicity – mark all that apply: ☐ European ☐ Middle Eastern, North African, Arab ☐ African, Caribbean Islander ☐ Spaniard, Mexican, Central, South, or Latin American Puerto Rican, Cuban ☐ Canadian / Latin American Indian

Demographics	**Household Members & Income** **MUST** be complete to ensure payment
Marital Status: ☐ Married ☐ Never married ☐ Widowed ☐ Divorced ☐ Separated	
Level of Education: ☐ Less than high school ☐ High school graduate ☐ Some college ☐ College graduate	**# of people in the household** (including yourself)**:**
Employment Status: ☐ Full-time ☐ Not Employed ☐ Part Time ☐ Retired	**Household Yearly Income: $**

Provider (Primary Care) **Information**

Do you have a regular Primary Care Provider (doctor/nurse practitioner/clinic)? ☐ Yes ☐ No* *If NO, client **MUST BE** provided with referral resources for enrollment with a PCP.

May we send your test results to your provider? ☐ Yes ☐ No

Physician Name:	Physician Address:

Alternate Contact Information

Name:	**Is this person a:** ☐ Spouse ☐ Child ☐ Friend ☐ Neighbor ☐ Relative ☐ Other _____
Phone Number: ( ) -	Email Address (if available):

INSURANCE INFORMATION (bring ***ALL*** cards with you)
Provider: Please fax copy of card to MCRCEDP & retain in patient medical record.

☐ None
☐ Medicaid # _____
☐ Medicare Part A Only # _____
☐ County Health Plan HPMS _____
☐ Blue Cross _____
Contract # Group # Deductible $
☐ Other _____
Contract # Group # Deductible $

Program Staff Use Only:
MBCIS # _____ Client ID: _____

Insurance Deductible Amount: $_____
(out-of-pocket expense)

Eligible: ☐ Yes ☐ No ☐ Referral to HMP/Medicaid ☐ Referral to ACA Marketplace Insurance

Michigan Colorectal Cancer Early Detection Program (MCRCEDP) Enrollment Form

Patient Name:

PROGRAM STAFF USE ONLY:

Scheduling:

Indication for initial test: ❑ Screening ❑ Surveillance ❑ Diagnostic (MDHHS Authorization)

Test: ❑ FIT ❑ Colonoscopy ❑ Other _____

Date FIT kit distributed to client: (MM/DD/YYYY) _____/_____/_____

**** MUST complete a FIT or Colonoscopy Intake Form ****

MEDICAL HISTORY (Staff must Review this Section with Client)

Have you ever had any of the following colorectal screening tests: ❑ Yes ❑ No ❑ Unknown

TEST	**DATE** (MM/DD/YYYY)	**RESULTS (check one)**
❑ Take Home FOBT/FIT	/ /	❑ Normal/Negative ❑ Abnormal/Positive ❑Unknown
❑ Colonoscopy	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown
❑ Sigmoidoscopy	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown
❑ Double Contrast Barium Enema (DCBE)	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown
❑ Other _____	/ /	❑ Normal ❑ Polyp(s)/Tumor(s)/Cancer ❑Unknown

Have you ever been told by a Health Professional that you have:

Crohn's Disease ❑ Yes ❑ No ❑ Unknown
Familial Adenomatous Polyposis (FAP) ❑ Yes ❑ No ❑ Unknown
Lynch Syndrome (HNPCC) ❑ Yes ❑ No ❑ Unknown
Inflammatory Bowel Disease (IBD) ❑ Yes ❑ No ❑ Unknown
Ulcerative Colitis ❑ Yes ❑ No ❑ Unknown

Have you ever been told you have/had colorectal cancer? ❑ Yes ❑ No ❑ Unknown
If yes, Date of Diagnosis? (MM/DD/YYYY) _____/_____/_____ Age:_____

Have you ever been told you have/had colorectal polyps? ❑ Yes ❑ No ❑ Unknown
If yes, Date (MM/DD/YYYY): _____/_____/_____
Were any of the polyps precancerous? ❑ Yes ❑ No ❑ Unknown

Do you have an immediate family member who has ever been diagnosed with colorectal cancer, or precancerous polyps? ❑ Yes ❑ No ❑ Unknown
Please circle relative: Mother Father Sister Brother Child
Relative(s)Age at Diagnosis: _____

Are you currently experiencing any of the following?

Rectal Bleeding (in the past six months)? ❑ Yes ❑ No ❑ Unknown
Blood in your stool (in the past six months)? ❑ Yes ❑ No ❑ Unknown
Diarrhea (lasting more than 1-2 weeks)? ❑ Yes ❑ No ❑ Unknown
Constipation (lasting more than 1-2 weeks)? ❑ Yes ❑ No ❑ Unknown
Unexplained weight loss? ❑ Yes ❑ No ❑ Unknown
Lower abdominal pain? ❑ Yes ❑ No ❑ Unknown

Do you now smoke cigarettes? ❑ Every day ❑ Some Days ❑ Not at all
Are you interested in quitting smoking? ❑ Yes ❑ No ❑ I do not smoke

HEALTH DEPARTMENT of Northwest Michigan

Michigan Colorectal Cancer Early Detection Program
Record of Informed Consent

The Health Department of Northwest Michigan is offering the Michigan Colorectal Cancer Early Detection Program (MCRCEDP) to low-income men and women who are uninsured or underinsured, age 50-64, and are at average or increased risk for colorectal cancer, and not currently enrolled in the Healthy Michigan Plan.

PURPOSE OF THIS PROGRAM

The purpose of the Michigan Colorectal Cancer Early Detection Program is to find out if an eligible client has colorectal cancer and, if he/she has cancer, to refer them for treatment. Regular cancer screening tests can help find a cancer that may be present when it is still very small. If cancer is found before it has spread to other parts of the body, chances of survival are much better.

WHAT SERVICES WILL I GET WHEN I ENROLL IN THE MCRCEDP

1. Fecal Immunochemical Test (FIT) At-Home-Test.
   - The FIT is a screening test for cancer of the colon and rectum. It looks for blood in the stool even when a person cannot see the blood. The test is an at-home procedure of collecting two samples from three different stools.
   - Blood can be in the stool because of cancer and also because of other problems. Some medications and some foods may also affect the test results.
2. Colonoscopy
   - The FIT may not be the only test you need.
   - You may also need a doctor to look at your entire colon (colonoscopy) if the FIT shows a need for follow-up of abnormal screening results or if you are at increased risk for colorectal cancer due to personal or family history.

WHO WILL PAY FOR THE MCRCEDP SERVICES: **INITIALS_____**

- The MCRCEDP pays for the Fecal Immunochemical Test for colorectal cancer screening. If the FIT is abnormal, the program will pay for a diagnostic colonoscopy.
- The MCRCEDP pays for a screening colonoscopy if you are at increased risk for colorectal cancer due to personal or family history.
- The MCRCEDP will pay for polyp removal during a colonoscopy and biopsies if needed. There may be other associated costs not covered by this program.
- My provider may recommend other tests or procedures either not covered by the MCRCEDP or are not related to colorectal cancer.
- If I agree to get these other screening/follow-up tests or procedures, the MCRCEDP will not be able to pay for them. I may have to pay for these additional services.

WHAT IF MY FIT IS ABNORMAL **INITIALS_____**

- I will get the results of my FIT and be told of any additional follow-up that I may need.
- If my FIT is abnormal, the Health Department staff will help me make plans for additional diagnostic tests (colonoscopy) to decide if there is a problem.
- It is my choice whether or not to follow the recommendations for follow-up of any abnormal tests.
- Not all follow-up services are free. I understand that the MCRCEDP cannot pay for all of the charges related to the diagnostic tests. If I am unable to pay, the MCRCEDP agency will work with me to see that I get the services I need.
- If I have another provider, I can give the MCRCEDP written permission to send them my test results.

WHAT IF I AM DIAGNOSED WITH COLORECTAL CANCER? INITIALS_____

- I understand that the MCRCEDP does not pay for any treatment services for colorectal cancer such as: Surgery, Chemotherapy, Radiation, Medications, and Home Health Care, etc.
- If colorectal cancer is diagnosed, the Health Department will refer me to providers who work with this program who will help me get colorectal cancer treatment.
- If you are unable to pay for treatment, the Health Department will make every attempt to work with you to assure that you receive appropriate services.

THINGS I NEED TO KNOW ABOUT SCREENING TESTS

- The risks associated with the screening tests are low.
- I may ask for and receive any information the MCRCEDP agency or provider has that will help me better understand the screening procedures and risks.
- I may ask questions at any time.
- No screening test is 100 % accurate. Screening tests can sometimes miss an abnormality or show an abnormality when one is not present.
- Getting normal test results today does not mean that cancer cannot develop later. These tests do not prevent cancer. It is important that you receive screenings regularly.
- If my screening is abnormal it does not always mean cancer. Only some men and women with abnormal screening results will, after more tests, be diagnosed with cancer. Some medicine and foods may affect the test results.

I AGREE TO:

☐ Complete the FIT within a week and return it as instructed (or)
☐ Complete the prep and screening colonoscopy as scheduled.

- Provide the MCRCEDP with information about me, including my health history.
- Allow the MCRCEDP to exchange information regarding my case with my private provider, any consulting providers, any clinic or hospital to which I may be referred, my health insurance company, the Michigan Department of Community Health, the Michigan Public Health Institute, and the agency coordinating this program for the State of Michigan.
- Be contacted if follow-up appointments are necessary and when it is time to schedule the next yearly screening check-up.

When I enroll in the Program, I will be asked if I have health insurance. I am eligible to receive Program services only if I am uninsured or underinsured and not enrolled in the Healthy Michigan Plan.

- If I receive Program services and I did not tell the truth about my insurance status, I will be responsible for all cost of Program services that I have received.

I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll. The Health Department phone number is (800) 432-4121.

_____

Signature of Client Date

_____

Signature of Person Obtaining Informed Consent Date

CONTENTS OF THIS FORM REMAIN IN EFFECT UNTIL NEXT ANNUAL VISIT.