MDHHS-6126, BREAST AND CERVICAL CANCER CONTROL NAVIGATION PROGRAM (BC3NP) AND WISEWOMAN ENROLLMENT

Michigan Department of Health and Human Services (MDHHS)

(Revised 3-25)

SECTION 1 – ENROLLMENT INFORMATION

Enrollment/Clinic Site	Enrollment Date

☐ **Baseline** Enrollment ☐ **Returning** Annual Enrollment

SECTION 2 – CLIENT CONTACT INFORMATION (please print)

Last Name	First Name	Middle Initial	Date of Birth
Social Security Number	Michigan Breast and Cervical Information System (MBCIS) Number		
Street Address	Apartment Number	PO Box	
City	State	Zip Code	County

Phone Number ☐ Home ☐ Work ☐ Cell ☐ Other

Email Address

☐ I do **not** wish to receive communications from the local WISEWOMAN agency (LWAs) and/or MDHHS.

Race and Ethnicity (select all that apply)

☐ White
☐ Black/African American
☐ Asian
☐ Arab/Arab American
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander
☐ Prefer not to answer
☐ Unknown/did not answer

Are you Hispanic or Latino?
☐ Yes ☐ No ☐ Unknown ☐ Prefer not to answer

SECTION 3 – SERVICE INFORMATION

What services do you need? (select all that apply)

☐ Mammogram (Mamm) ☐ Pap test ☐ HPV test
☐ Follow up for an abnormal mammogram and/or breast exam (also known as diagnostics)
☐ Follow up for an abnormal Pap test and/or HPV test (aka diagnostics)
☐ Heart Disease Risk Assessment (WISEWOMAN services, where available)

Barriers Identified – Do you need help with any of the following to receive services? (Select all that apply.)

☐ No problems
☐ Problems getting time off work
☐ Family care issues
☐ Help with scheduling appointments
☐ Insurance issues
☐ Language/Translation services needed
☐ No health care provider
☐ Transportation
☐ Education on screening/diagnostic procedure
☐ Other

SECTION 4 – DEMOGRAPHICS

Level of Education

☐ Less than high school	☐ High school graduate	☐ Some college
☐ College graduate	☐ Prefer not to answer	☐ Other

Relationship Status

☐ Single	☐ Separated	☐ Married
☐ Divorced	☐ Widowed	☐ Partner
☐ Other		

Employment Status

☐ Full-time	☐ Not employed	☐ Part-time
☐ Retired	☐ Prefer not to answer	☐ Other

Household Members and Income (Must be completed for program eligibility.)

Yearly Income	Number of people that the client’s yearly income supports (including client)

BC3NP MEDICAL HISTORY AND RISK ASSESSMENT

SECTION 5 – PATIENT INFORMATION

Patient Name	Birth Date

SECTION 6 – BREAST HISTORY

Previous Mammogram? (Mamm)	☐ Yes	☐ No	Date
Previous Clinical Breast Exam (CBE)	☐ Yes	☐ No	Date
Previous Breast Biopsy	☐ Yes	☐ No	Date
Have you been told you are at high risk for developing breast cancer?	☐ Yes	☐ No	
Have you received an MRI for being at high risk for developing breast cancer?	☐ Yes		Date

Breast Cancer Risk – Select at least one of the below indicates increased/high-risk for breast cancer.

☐ No Risk: Average (Mamm Only) ☐ Unknown (Mamm Only) ☐ Not Assessed (Mamm Only)

- ☐ Personal history/family member with BRCA/another gene mutation
- ☐ Personal lifetime risk of ≥ 20-25% or > 1.7% (Gail model)
- ☐ Radiation treatment to the chest between ages 10-30
- ☐ History of atypical hyperplasia or Lobular carcinoma in situ
- ☐ Personal/family history of genetic syndromes

HIGH RISK – Contact MDHHS for approval of MRI

- ☐ Personal/family history of ovarian cancer
- ☐ Three or more family members with breast cancer
- ☐ Family member diagnosed with breast cancer under age 50
- ☐ Other

AVERAGE RISK – May be at high risk contact MDHHS for approval of MRI

SECTION 7 – CERVICAL HISTORY

Previous Pap Test?	☐ Yes	☐ No	Date
Previous Human Papillomavirus (HPV) Test	☐ Yes	☐ No	Date
History of hysterectomy	☐ Yes	☐ No	Date
Do you have a cervix?	☐ Yes	☐ No	☐ Unknown

Reason for Hysterectomy ☐ Pre-cervical cancer ☐ Cervical cancer ☐ Other

Cervical Cancer Risk – Select at least one of the below indicates high-risk for cervical cancer.

- ☐ No Risk: Average (regular screening) ☐ Unknown (regular screening)
- ☐ Not Assessed (regular screening)
- ☐ Prior history of pre-cervical cancer or cervical cancer
- ☐ Prior DES exposure
- ☐ HIV/AIDS infection
- ☐ Organ transplantation
- ☐ Immunosuppression from other causes
- ☐ Other

SECTION 8 – PERSONAL CANCER HISTORY

☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

☐ Other Cancer Year

SECTION 9 – FAMILY HISTORY OF CANCER

Do you have a family history of Cancer?

☐ Yes (If yes, complete information below.) ☐ No ☐ Unknown

Relationship 1

☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt

☐ Father ☐ Brother ☐ Grandfather ☐ Uncle

Relationship Type 1

☐ Maternal ☐ Paternal Age

Cancer 1

☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

Relationship 2

☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt

☐ Father ☐ Brother ☐ Grandfather ☐ Uncle

Relationship Type 2

☐ Maternal ☐ Paternal Age

Cancer 2

☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

SECTION 10 – TOBACCO HISTORY

Do you use any tobacco or smokeless tobacco products?

☐ Every day ☐ Some days ☐ Not at all

Interested in quitting tobacco? ☐ Yes ☐ No ☐ Don’t use tobacco

SECTION 11 – TO BE COMPLETED BY THE ENROLLMENT SITE/AGENCY/CLINIC

Michigan Tobacco Quitline Referral (fax sent) ☐ Yes ☐ No

SECTION 12– COMMENTS

Comments

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Michigan Department of Health and Human Services (MDHHS)

Please note: If needed, free language assistance services are available.
Call 844-446-8727 (TTY 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-446-8727 (TTY 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-446-8727 (رقم هاتف الصم والبكم: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-446-8727 （TTY 711）
Syriac (Assyrian)	ܙܘܗܪܐ: ܐܢ ܐܚܬܘܢ ܟܐ ܡܗܡܙܡܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܡܝ ܒܠܘܢ ܕܦܠܚܝܬܘܢ ܒܚܠܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܬܢܐ 844-446-8727 (TTY 711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-446-8727 (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 844-446-8727 (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-446-8727 (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 844-446-8727 (TTY ১ 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-446-8727 (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 844-446-8727 (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-446-8727 (TTY 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-446-8727（TTY 711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-446-8727 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 844-446-8727 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-446-8727 (TTY 711).

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Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax), MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.