Cortland & Tompkins Counties
Cancer Services Program

Screening Eligibility Form
Fax to (607-756-3419)

DATE OF INTAKE______________________________

CLIENT NAME__________________________________

PHONE____

PREVIOUS CLIENT: Yes No Year________

Eligibility Criteria (40-64 years old)

1) AGE___________ DATE OF BIRTH____________

Primary family history of breast cancer
Mother Daughter Sister Age Diagnosed________

2) HEALTH INSURANCE

Do you have Medicare A only _____
(if yes then eligible for CSP)

Do you have Medicare A&B or B only _____
(If yes Medicare will pay for screenings, CSP only if Medicare denies)

Do you have Medicaid ____
(If yes, then not eligible for CSP)

Do you have private insurance ______

Carrier: ____

____Deductible too high (eligible for CSP)
____Insurance does not cover screening (eligible for CSP)
Insurance will be billed first, requires denial letter from insurance company.

Do you have Family Planning Benefits Program _______

I do not have any insurance ______ (private or public)

3) INCOME

Monthly for household __________________
Number of people in household __________

- If client meets eligibility criteria, please complete the back of this form.

Maiden Name_________________________________

Address____

City____________________________**State**________**Zip**______________

County________________**Country of birth**_____________**SS#**_______________

Race (circle one) White Black Asian American Indian Other Unknown

Hispanic origin (circle one) Yes No Unknown

Name, and phone number of a **person to contact** that does NOT live with you

Name:____________ __________ Phone:_____________

Previous mammogram (circle one) Yes No Unknown
If yes: Date______________ Place___________________________

Previous Pap smear (circle one) Yes No Unknown
If yes: Date______________ Place___________________________

Last menstrual period___________ or date of hysterectomy____________________
*** If cervix was removed CSP can **not** pay for a pap test.

How did you hear of our program?

___ Reminder received mail or phone
___ TV/Radio
___ Outreach worker
___ Newspaper
___Word of mouth
___ Pamphlet, Brochure
___ Educational Program
___ Clinic or Doctor
___Other______________________
Please list.

Does Colon Cancer run in your family? ______ Yes or No_____

If Yes, who and how old when they were diagnosed? __________________________

Have you had colon cancer screening? ____ Yes or No_____ If Yes, What did you do and When? __________________________________

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*PROVIDER OFFICE TO COMPLETE *PROVIDER NAME*____________________*
CBE / EDUCATION DATE______________________________

PAP DONE _____ Yes Date____
_____ No Reason____
(hysterectomy, refused, not needed done in last year)
SCRIPT GIVEN FOR MAMMOGRAM _____Yes _____No