

Breast & Cervical Health Check Annual Enrollment Form

Clinic Name:		Medical Record No:			Appointment: - -	
Last Name:		First Name:			MI:	
Address:		City/State/Zip:				
Soc Sec No:		Date of Birth: - -		Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other		
Latina/Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No				Other Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Eskimo <input type="checkbox"/> Other Alaska Native (Check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Aleut <input type="checkbox"/> American Indian						
Most recent Pap test you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never Most recent Mammogram you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never						
Do you smoke or chew tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/>						
Medical Coverage: <i>Check all that apply.</i> <input type="checkbox"/> Medicare Part B – Not eligible for BCHC* <input type="checkbox"/> None <input type="checkbox"/> Medicaid/Denali Care ID number: _____ <input type="checkbox"/> Insurance Company name: _____ (on insurance card)						
Household Income:						
1. Circle the number of people living in your household. The number in your household includes yourself, a spouse, relatives and all the children who live with you.						
2. Circle the household income (or range) on the same line where the household size is circled. Household income includes all money from jobs, tips, alimony, child support, public assistance, disability, social security, unemployment, and Permanent Fund Dividends.						
Monthly	Household	Less Than	Between	Between	Between	More Than
	1	\$ 1,693	\$1,694 - \$1,840	\$1,841 - \$2,453	\$2,454 - \$3,067	\$ 3,067
	2	\$ 2,291	\$2,292 - \$2,490	\$2,491 - \$3,320	\$3,321 - \$4,150	\$ 4,150
	3	\$ 2,889	\$2,890 - \$3,140	\$3,141 - \$4,187	\$4,188 - \$5,233	\$ 5,233
	4	\$ 3,487	\$3,488 - \$3,790	\$3,791 - \$5,053	\$5,054 - \$6,317	\$ 6,317
	5	\$ 4,085	\$4,086 - \$4,440	\$4,441 - \$5,920	\$5,921 - \$7,400	\$ 7,400
	6	\$ 4,683	\$4,684 - \$5,090	\$5,091 - \$6,787	\$6,788 - \$8,483	\$ 8,483
	7	\$ 5,281	\$5,282 - \$5,740	\$5,741 - \$7,653	\$7,654 - \$9,567	\$ 9,567
OR Or add \$1,083.00 for each additional person.						
Yearly	Household	Less Than	Between	Between	Between	More Than
	1	\$ 20,314	\$20,315 - \$22,080	\$22,081 - \$29,440	\$29,441 - \$36,800	\$ 36,800
	2	\$ 27,490	\$27,491 - \$29,880	\$29,881 - \$39,840	\$39,841 - \$49,800	\$ 49,800
	3	\$ 34,666	\$34,667 - \$37,680	\$37,681 - \$50,240	\$50,241 - \$62,800	\$ 62,800
	4	\$ 41,842	\$41,843 - \$45,480	\$45,481 - \$60,640	\$60,641 - \$75,800	\$ 75,800
	5	\$ 49,018	\$49,019 - \$53,280	\$53,281 - \$71,040	\$71,041 - \$88,800	\$ 88,800
	6	\$ 56,194	\$56,195 - \$61,080	\$61,081 - \$81,440	\$81,441 - \$101,800	\$ 101,800
	7	\$ 63,370	\$63,371 - \$68,880	\$68,881 - \$91,840	\$91,841 - \$114,800	\$ 114,800
Or add \$13,000.00 for each additional person.						
I want to enroll in BCHC. The information I provided here is correct.						
Client Signature: _____ Date: _____						
If not completed by the woman named above, but recorded from information provided by her:						
Organization: _____ by _____ on _____						

IF YELLOW SECTIONS ARE NOT COMPLETE WHEN THE FORM IS SUBMITTED, PAYMENT FOR SERVICES WILL BE DELAYED.
THIS FORM MUST BE SUBMITTED TO: State of Alaska / BCHC, 3601 C Street, Suite 322, Anchorage, AK 99503
FAX: (907) 269-3414

Revised
09/2015

**Breast & Cervical Health Check
Client Information Handout**

If you are eligible and wish to enroll in Breast & Cervical Health Check (BCHC) here are some things you will need to know. BCHC is the State of Alaska's program that pays for breast and cervical cancer screening and many diagnostic services.

- BCHC does not cover the cost of all tests or services you may need. You may need to pay for the tests or services not covered by BCHC.
- Ask your provider whether you may have to pay for some services.
- If you have health insurance, your insurance will be billed before BCHC is billed.
- You may receive statements about the cost of your care.
- Read and keep track of all your statements. If you think there is an error or you have questions, call BCHC at 1-800-410-6266.
- Based on the information you provided, you may be sent additional information regarding services available.
- BCHC refers women to Medicaid when treatment is needed. Referral to Medicaid does not guarantee coverage.
- BCHC treats all clinical and personal information as confidential.
- Your enrollment in BCHC is good for one year from the date you enroll.

I enrolled on _____ My BCHC clinic is _____

Please keep for your records

Client

**State of Alaska Department of Health and Social Services
NOTICE OF USE OF PRIVATE HEALTH CARE INFORMATION**

Effective Date April 14, 2003

Updated September 1, 2013

<p>FOR YOUR PROTECTION</p>	<p>THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.</p>
<p>Your Health Care Information Is Private</p>	<p>We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are required by law to maintain the privacy of protected health information and to provide notice of our legal duties and privacy practices with regard to your protected health information. We are committed to protecting your health care information and following all laws about its use, and we are required to abide by the terms of this notice. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:</p> <ol style="list-style-type: none"> 1. We must keep your health care information from others who do not need it. 2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.
<p>Who Sees And Shares My Health Care Information?</p>	<p>Your health caregivers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later.</p> <p>We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.</p>
<p>How Is Payment Made</p>	<p>We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.</p>
<p>May I See My Health Care Information?</p>	<p>In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information. We may charge a small amount for copying costs.</p> <p>If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information unless it was disclosed for treatment, payment or operations purposes.</p>

<p>What If My Health Care Information Needs To Go Somewhere Else?</p>	<p>You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.</p> <p>The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.</p> <p>Note: If you are younger than 18 years old and, by law, you are able to give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.</p>
<p>Could My Health Care Information Be Released Without My Authorization?</p>	<p>We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:</p> <ol style="list-style-type: none"> 1. contagious diseases, birth defects and cancer; 2. firearm injuries and other trauma events; 3. reactions to problems with medicines or defective medical equipment; 4. to the police when required by law; 5. when the court orders us to; 6. to the government to review how our programs are working; 7. to a provider or insurance company who needs to know if you are enrolled in one of our programs; 8. to Workers Compensation for work-related injuries; 9. birth, death and immunization information; 10. to the federal government when they are investigating something important to protect our country, the President and other government workers; 11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults. <p>We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.</p> <p>Other uses and disclosures of your health care information will be made only with your written authorization, which you may revoke at any time.</p> <p>To revoke an authorization please use form 06-5872 (Revocation of Authorization For Release of Information). This form may be obtained by contacting the Department Privacy Officer. Contact information for the Privacy Officer is located at the bottom of this notice.</p> <p>Most uses and disclosures of psychotherapy notes require an authorization.</p>
<p>Additional Rights</p>	<p>You have the following rights with respect to your protected health information:</p> <ol style="list-style-type: none"> 1. to receive confidential communications; 2. to receive notification of a breach of your protected health information; and 3. to request that we restrict a disclosure to a health plan when you pay in full for a covered service.
<p>May I Have a Copy of This Notice</p>	<p>This notice is yours. You may ask for a copy at any time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan, such as Medicaid. An electronic version of this notice is available at: http://dhss.alaska.gov/Documents/Pdfs/DHSS Notice of Privacy Practices.pdf</p>

Questions or Complaints	<p>If you have questions or feel your privacy rights have been violated you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by emailing PrivacyOfficial@health.state.ak.us. You will not be retaliated against for filing a complaint with DHSS or the Secretary of Health and Human Services.</p> <p>You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. Your health care services will not be affected by any complaint made to the Department Privacy Official, Secretary of Health and Human Services or Office of Civil Rights.</p>
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