*Iowa Get Screened:* Colorectal Cancer Program

# Client Ineligibility Form

**Program #:** ______________ **Client #:** _________________ (if applicable) **Date of Birth:** ______/______/_______ (mm/dd/yyyy)

**Name:** ______________________, ____________________ **Telephone:** (_____) ______-________
Last Name First Name

**Address:** ____________________________________________________________
Street Address City State Zip

## Ineligible

Complete this section if the client is:

- Not eligible; or
- Not interested in participating; or
- Not available through usual contact sources/lost to follow-up.

Ineligibility Date ______/______/_______
(mm/dd/yyyy)

Reason(s) client is ineligible:

- ☐ Does not meet screening eligibility criteria (must be at an average or increased risk to be eligible)
- ☐ Age (i.e. under 50 years old or over the age of 64)
- ☐ Income (above 250% of Federal Poverty Guidelines)
- ☐ Obtained insurance (includes Medicare/Medicaid and BCCT Medicaid coverage)
- ☐ Allotted screening numbers (spaces) at site have been used.
  - Would the patient like to be contacted if more spaces become available?
    - ☐ YES
    - ☐ NO
- ☐ Moved out of state
- ☐ Lost to follow-up (cannot be located)
- ☐ Declined re-enrollment
- ☐ Deceased
- ☐ Other ___________________________

Comments:_________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

## Reactive

Complete this section if a client re-enrolls in the program that was previously deemed ineligible.

Most recent consent date: ______/______/_______
(mm/dd/yyyy)

Reactivation Date: ______/______/_______
(mm/dd/yyyy)

**Please mail or FAX this form to:**

**Iowa Get Screened Program**
*Gena Hodges, Project Coordinator*
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0075
FAX: (515) 242-6384