Iowa Care for Yourself Program – Comprehensive Services

Informed Consent and Release of Medical Information

Program #: _____ **Client #:** _____ **Date of Birth:** _____/_____/_____

Name: _____ **Home Phone:** (_____) _____-_____
PLEASE PRINT

Cell Phone: (_____) _____-_____

Address: _____
PLEASE PRINT ***STREET*** ***CITY*** ***STATE*** ***ZIP***

*** Read about program services on the back of this consent.**
*** Sign this consent to be part of the *Care for Yourself* - Comprehensive Screening Program.**

1) I want to be a part of the *Care for Yourself* (CFY) Program. This program screens women for breast and cervical cancer and screening services for heart disease and stroke risk factors. To be a part of the program, I must be between the ages of 40-64, earn less than the set income guidelines, underinsured or uninsured and not have Medicare Part B.
2) Being part of this program is my choice, however once I enroll; I must complete all of the necessary screenings I am eligible for recommended by the program. Prior to receiving screenings services, I will inform the CFY staff if I no longer wish to be part of the CFY program and receive CFY screening services.

Contact your local coordinator
right away if you have any questions.

_____
(LOCAL COORDINATOR NAME)

_____
(PHONE NUMBER)

3) I have discussed with the program staff about how I will pay for tests or services that are not covered by the *Care for Yourself* Program.
4) I accept responsibility for following advice my health care provider may provide.
5) I give permission for my health care provider, laboratory, clinic, radiology unit and/or hospital to provide the *Care for Yourself* Program results of my breast and cervical cancer screening exams, and/or cardiovascular and stroke screening results, follow-up exams and treatment within six months from my screening date.
6) *Care for Yourself* will use my name, address, and other personal information to remind me of screening, follow-up exams, and to help me find treatment.
7) I will discuss my screening values with the program coordinator who will suggest changes to help me address my risk factors.
8) I will participate in health coaching services or attend Weight Watchers® if these options are offered to me.
9) Please contact the person who is listed below, who does not live with me, if you cannot reach me with important information about my health.

Name: _____ **Phone:** (_____) _____-_____ **Relationship:** _____
PLEASE PRINT

Address: _____
STREET *CITY* *STATE* *ZIP*

10) I release this program and its employees and agents from any claims, demands, and actions related to my participation in *Care for Yourself*. This includes any claims related to a failure to detect or diagnose cancer and/or heart disease and stroke, failure of treatment, or any acts or omissions related to diagnosis or treatment while I am part of the program.

_____ _____ _____ _____
Client Signature **Date** **CFY Coordinator Signature** **Date**

WHITE – Local Program File **YELLOW – Participant**

HIPAA allows for disclosure of protected health information to public health authorities for public health activities. Updated July 2014

***Care for Yourself* (CFY) can pay for:**	
If I am under 40 years old	• An office visit with a doctor or nurse for clinical breast exam if I have breast cancer symptoms (e.g. a breast lump). • A diagnostic mammogram or breast ultrasound, if my clinical breast exam is abnormal.
If I am an eligible participant between the ages of 40-64	**Screening Tests and Procedures** • Office visit that includes appropriate/recommended breast and cervical cancer screening and cardiovascular screening; • Clinical Breast Exam; • Pelvic Exam; • Pap Test, as eligible and recommended by provider; • Two blood pressure measurements collected during the same date office visit; o If an **abnormal** value is identified, one follow-up office visit will be paid for o If an **alert** value is identified, one follow-up office visit will be paid for • Height, weight, hip circumference, and waist circumference; • Fasting blood lipid screenings; • Fasting glucose measurements or glycated hemoglobin HbA1c (only for clients with a non-fasting glucose and/or previously diagnosed with diabetes); o If an **alert** value is identified, one follow-up office visit will be paid for; • Tobacco cessation referral; • Mammography, as eligible and recommended by provider; • Breast and/or cervical diagnostic services, as recommended by provider; • Referral for cardiovascular diagnostics, as recommended by provider; • Referral for precancer and cancer treatment, as recommended by provider; • Three sessions of cardiovascular health coaching and/or referral to 16 sessions of Weight Watchers®.
***Care for Yourself* does <u>not</u> pay for:**	
If I am under 40 years old	• Any services unless I have breast cancer symptoms.
If I am under 40 or over 64	• Cardiovascular disease risk screening. • Cardiovascular health coaching and/or referral to lifestyle program.
Any Age	• Any cancer treatment. *If I am diagnosed with breast or cervical pre-cancer or cancer, program staff or Medicaid staff will check my income to help me find the best treatment resources. I may be required to prove my identity, that I am a United States citizen or legal alien, and provide income tax statement or paycheck stubs to prove my income to the Department of Human Services.* • Other tests the doctor may order such as urine or blood tests. • Exams I had before signing up for the program *(the date on the other side).* • Diagnostic exams not listed above. • Inpatient hospital or treatment services. Treatment includes any medical or surgical services prescribed by a doctor or nurse. • Diagnostic testing, treatment or medication prescribed by a doctor or nurse for heart disease or its risk factors.