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) WISEWOMAN Program. This program screens women for breast and cervical cancer and heart disease and stroke risk factors. To be a part of the program, I must be between the ages of 40-64, have an income at or less than 250% of the Federal Poverty level, be 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 and 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 program.

Contact your local coordinator
<u>right away</u> 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, 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 results with the program coordinator.
8) I will participate in health coaching services and attend healthy behavior support services (HBSS) offered to me.
9) I will complete the follow-up screening and the subsequent health coaching session offered to me.
10) I give permission for the HBSS providers to share information with the *Care for Yourself* program regarding my HBSS participation.
11) I give permission for the *Care for Yourself* program to provide information to my health care provider regarding my referral and participation in health coaching and HBSS.
12) If you cannot reach me, please contact the person listed below, with important information about my health.

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

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

13) 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 August 2021

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;
	• Mammography, as eligible and recommended by provider;
	• Breast and/or cervical diagnostic services, as recommended by provider;
	• Referral for precancer and cancer treatment, as 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 (HbA1c only for clients with a non-fasting glucose and/or previously diagnosed with diabetes);
	• Referral for cardiovascular diagnostics, as recommended by provider;
	• Tobacco cessation referral;
	• Three sessions of health coaching;
	• Referral and participation in Healthy Behavior Support Services;
	• Follow-up screening visit following completion of health coaching;
	• One session of health coaching that follows the follow-up screening visit.

***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 • Referral and participation in Healthy Behavior Support Services.
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.