New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information

Participant ID: _____
Contractor ID: _____
Fax Number: _____

Signing this consent means that:

- I have read the program information on page 1 and have talked to a CSP contractor staff or provider and understand the services being offered to me by the CSP.
- I agree to be in this program and understand that by agreeing to be in this program, I give permission to the New York State Department of Health, contract administrators and health care providers, including doctors, clinics, and/or hospitals to release (share) information about me. I understand this information includes financial and insurance information and medical information about me and related to my breast, cervical and/or colorectal cancer screening, and any related diagnostic and treatment care I receive. I understand this information will be released (shared) to other health care providers, contract administrators, other staff, health care providers or agencies participating in the CSP and the New York State Department of Health for my health care, treatment and follow-up, and for case management, tracking and payment purposes.
- I understand that information about me and my medical information will be released only as allowed by this consent or as allowed or required by law.
- I understand that this consent is for CSP cancer screening and related diagnostic and treatment services and case management, as needed and as provided under the Cancer Services Program.
- I understand that I may choose not to have the services that are offered to me at any time.
- I understand that someone will contact me if I am found to have an abnormal screening test (my screening test shows that I may have cancer). Case management services are provided to help me to get the recommended diagnostic follow-up testing and treatment, if needed. I understand that case management services are provided at no cost to me and that I can choose not to have the service at any time.
- I understand that my healthcare provider may recommend tests or procedures that may not be paid for under this program.

Attestation of Eligibility

A CSP staff person or provider told me about the program services and eligibility requirements and answered any questions I had. By signing this consent, I attest that to the best of my knowledge, I understand this information and by checking the boxes below, the following is true. I understand that the CSP and the New York State Department of Health may verify (check) the information I have provided herein.

I meet the following income eligibility requirements (choose one):

☐ My household income is at or below 250% of the Federal Poverty Guideline (FPG).

☐ My household income is above 250% of the FPG, but I cannot afford cancer screening/s.

I meet the following insurance eligibility requirements (choose one):

☐ I do not have health insurance of any type (this includes Medicare, Medicaid, Family Health Plus, or other public or private insurance).

☐ My health insurance deductible, monthly spend down, or co-payment is too high and prevents me from getting cancer screening services or my health insurance does not provide coverage for cancer screening and/or diagnostics.

☐ I authorize information about my services to be left on my **answering machine/voicemail.**

☐ I authorize the CSP to send me reminder **text messages.**

Client Information and Signature

Client Name (Print) _____ DOB _____

Client Signature _____ Date _____

Contractor Witness (Signature) _____ Date _____

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CONSENT FOR CANCER SERVICES PROGRAM PARTICIPATION

About the Cancer Services Program (CSP)

The CSP is a New York State Department of Health (NYSDOH) program that works with contract administrators, and with doctors, nurses and other health care providers to offer free, age-appropriate, risk-based screening for breast cancer, cervical (opening of the womb) cancer, and colorectal (the colon and rectum) cancer. Screening tests can help find these cancers in early stages when they may be easier to treat. Sometimes, when these cancers are found and treated early, they can be cured. Contract administrators work with you, health care providers and the NYSDOH to provide the services described in this consent.

The Age-Appropriate, Risk-Based Screenings Offered by the CSP are:

- Mammograms and clinical breast exams for breast cancer
- Pap tests and pelvic exams for cervical cancer
- Take home fecal tests (FIT or FOBT) for colorectal cancer
- Screening colonoscopy for men and women at increased risk for colorectal cancer (this means they have a greater chance of getting colorectal cancer)

People Who Have Abnormal Screening Tests (the screening tests show they may have one of these cancers) May Also Have the Following Services from the CSP:

- Diagnostic tests: These are tests and exams that check to see if cancer is there.
- Case management: People help you get to the diagnostic tests by helping make appointments, finding a way to appointments, finding child care, and many other ways to make it easier to get to the important diagnostic test appointments.
- Help finding treatment if cancer is found.
- Help getting in the Medicaid Cancer Treatment Program if you meet the program eligibility (rules). The Medicaid Cancer Treatment Program offers full Medicaid insurance for people with breast, cervical, colorectal or prostate cancer who meet the program eligibility (rules).

Income and Insurance Eligibility

Free cancer screening by the CSP is only offered to women and men who meet income and health insurance eligibility (rules). Income eligibility means that the total amount of money earned by people living in your house must be below a certain amount for you to get free CSP services. CSP services are also offered to women and men who do not have health insurance (including Medicaid or other public insurance) or whose health insurance does not pay for cancer screenings. CSP services may also be offered to women and men who have health insurance, but cannot afford to pay the insurance co-pay, deductible, or spend down. The CSP contractor staff or health care provider will give you information about income and health insurance and talk to you about whether or not you meet these program rules.

Onondaga County
Cancer Services Program
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Client ID Number: _____
Partnership Name: _____
Fax Number: _____

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Phone: _____

Consent to Use of Disclose Health Information to Carry Out Treatment, Payment, or Health Care Operations

Your health information is confidential. State and federal laws restrict its use and disclosure.

By signing this consent form you authorize the Onondaga County Health Department to use and disclose your identifiable health information for treatment, payment, and health care operations.

This consent may be revoked by writing to the HIPAA Compliance Officer at the following address: **421 Montgomery Street- 9th Floor, Syracuse, NY 13202**. Consent may be revoked except to the extent that this organization has relied on it.

_____ _____
Signature of Patient/Client or Legal Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices

Please check the box below stating that you have received and retained a copy of the Notice of Privacy Practices:

☐ I have received a copy of the Onondaga County Health Department's Notice of Privacy Practices.

For OCHC Use Only:

Acknowledgement Not Obtained: ☐ Refused ☐ Other Staff Initials: _____