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

Client name or CSP ID#: _____

Fax #: _____

CONSENT FOR CANCER SERVICES PROGRAM PARTICIPATION

About the Cancer Services Program (CSP)

The CSP is a New York State Department of Health (NYSDOH) program. The CSP works with doctors, nurses, and other health care providers to offer free screening for breast cancer, cervical cancer, and colorectal cancer (also called colon cancer). Screening tests can help find these cancers early when they may be easier to treat. In some cases, screening can find cancer before it starts. CSP staff will work with you, health care providers, and NYSDOH to provide the services described in this consent.

The CSP offers these screenings:

- Mammograms for breast cancer
- Pap tests and high-risk human papillomavirus tests for cervical cancer
- Take home stool tests (Fecal Immunochemical Test [FIT] or Fecal Occult Blood Test [FOBT]) for colorectal cancer
- Screening colonoscopy for people who have a greater chance of getting colorectal cancer

The CSP offers follow-up services for people who have abnormal screening tests. An abnormal test means someone may have cancer.

- Diagnostic tests: Tests that check to see if cancer is there or not there.
- Case management: Help with making appointments, finding transportation, finding childcare, and other support to make it easier to get diagnostic tests.
- Help finding treatment if cancer is found.
- Help getting in the Medicaid Cancer Treatment Program if you meet the program rules. This program provides full Medicaid for people with breast, cervical, colorectal, or prostate cancer.

Income and Insurance Eligibility

The CSP provides no cost cancer screening and follow-up services to people who do not have health insurance. If you have health insurance, but the cost of cancer screening is still too high, you may be able to receive CSP services. You must also meet certain income rules to be able to get CSP services. CSP staff or a health care provider will talk to you about these rules and whether or not you are eligible for CSP services.

Signing this consent means that:

- I have read the program information on page 1. I have talked to a CSP contractor staff or provider, and I understand the services the CSP is offering me.
- I agree to be in this program. I understand that by agreeing to be in this program, I give permission to NYSDOH, CSP, and health care providers (including doctors, clinics, and hospitals) to share information about me. This information includes my financial, health insurance, and medical information related to my cancer screenings, and any follow-up and treatment care I receive. I understand this information will be shared with other health care providers, CSP staff, NYSDOH, and the Centers for Disease Control and Prevention. This information will be shared for health care and case management tracking and payment purposes.
- I understand that information about me and my medical information will be released only as allowed by me or required by law.
- I understand that this consent is for CSP cancer screening, related follow-up and treatment services, and case management as needed and as provided under the CSP.
- I understand that I may choose not to have the services offered to me at any time.
- I understand that someone will contact me if I have an abnormal screening test (my screening test shows that I may have cancer). Case management services are provided to help me get recommended follow-up testing and treatment, if needed. I understand that there is no cost to me for case management services and that I can choose not to have the service at any time.
- I understand that my health care provider may recommend tests or procedures that may not be paid for under this program.

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Attestation of Eligibility

A CSP staff person or provider has told me about CSP services and eligibility rules. This person answered any questions I had. By signing this consent, I confirm that, to the best of my knowledge, I understand this information. By checking the boxes below, I confirm that, to the best of my knowledge, the information is true. I understand that the CSP and NYSDOH may check the information I have provided.

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.

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 give permission for messages to be left on my voicemail about my services.

☐ I do NOT give permission for messages to be left on my voicemail about my services.

☐ I give permission for TEXT messages to be left on my voicemail about my services.

☐ I do NOT give permission for TEXT messages to be left on my voicemail about my services.

CLIENT INFORMATION AND SIGNATURE

Client Name (Print): _____ DOB:_____

Client Signature: _____ Date: _____

CONTRACTOR USE ONLY – Forms Received by:

☐ in person ☐ mail ☐ email ☐ fax

Contractor Signature _____ Date Received _____