Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

Please read each statement and sign at the bottom of the page.

I declare that:

1. I want to become a client of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level and I have no health insurance that pays for breast and cervical cancer screening exams.
3. I will no longer be eligible for FBCCEDP if my income changes to above 200% of the Federal Poverty Level.
4. I will call FBCCEDP once I enroll into health insurance and give them the name of the health insurance company, policy number and effective date. If my health insurance covers breast and cervical cancer screenings my screenings will no longer be paid for by FBCCP.
5. I will disclose any breast or cervical screening services that may impact my eligibility enrollment in FBCCEDP.

---

6. I may have a share of cost for some services.
7. I will use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test).
8. **I agree to complete any follow-up test within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.**

---

9. I will allow an exchange and release of my medical information between my health care providers, the FBCCEDP, the Florida Department of Health's Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination and procedure results, even if they were not paid by FBCCEDP.
10. I agree to receive phone or mail contact from FBCCEDP and the Department of Children and Families (DCF) Medicaid Program about my health care.
11. I understand that the FBCCEDP is a breast and cervical cancer **screening** program, not a cancer treatment program.
12. If I am diagnosed with breast or cervical cancer as a result of FBCCEDP screening, I will be referred to DCF Medicaid Program who will determine if I am eligible for Medicaid to cover treatment cost. I can reapply to FBCCEDP for screenings once treatment is completed.

---

13. This agreement is for **one** year unless my program eligibility changes. If my eligibility status changes or this agreement expires, I may be responsible for services provided during my FBCEEDP ineligible period.

______________________	______________________
Client signature	Date
______________________	______________________
Printed name	Date of birth

Revised June 2019