Enrollment #: _____

American Indian Cancer Foundation's
Screen Our Circle

Client Eligibility & Enrollment Form

* Indicates required fields

*Name:

First	Middle Initial	Last	Maiden

*Birth Date: MM/DD/YYYY

Age:

Social Security # (optional):

*Gender:
☐ Female ☐ Transgender Female
☐ Male ☐ Transgender Male

Address:

*City: State: Zip:

*Phone # 1 (home, cell, work): Best time to call:

Phone # 2 (home, cell, work): Best time to call:

Are you Hispanic or Latina? (Mexican, South or Central American, Puerto Rican, Cuban or other Spanish origin)
- ☐ Yes
- ☐ No

Select what applies best to you.
- ☐ American Indian or Alaska Native (specify): _____
- ☐ Asian (specify): _____
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander (specify):_____
- ☐ White/Caucasian
- ☐ Other (specify): _____

*In what country were you born? ☐ United States
☐ Other (specify) _____

*Do you have health insurance?
- ☐ Yes (specify): _____
- ☐ No
- ☐ Do not know

Have you used Indian Health Services (IHS) in the past year?
- ☐ Yes (specify clinic) : _____
- ☐ No
- ☐ Do not know

*Including yourself, what is the total number of people living in your household: _____

*What is your total household income (before taxes): $_____ yearly OR $_____ monthly

How did you hear about the program? Check all that apply.
- ☐ Television/Radio
- ☐ Newspaper/Flyer
- ☐ Internet/Social media
- ☐ Health care staff
- ☐ Organization
- ☐ Community event
- ☐ Family/Friend
- ☐ Other

Enrollment #: _____

Emergency Contact

Name:		Phone Number:
Address:		
City:	State:	Zip:

Personal Medical History

Please check all members who have had breast cancer:	☐ Self ☐ Parent ☐ Sibling ☐ Child		
Have you ever had a mammogram?	☐ Yes	☐ No	☐ Do not know
↳If YES: Approximately when was your last mammogram:			
Have you had a clinical breast exam (CBE) by a health care provider in the last two years?	☐ Yes	☐ No	☐ Do not know
Have you ever had a Pap test?	☐ Yes	☐ No	☐ Do not know
↳If YES: Approximately when was your last Pap test:			
Have you ever been told that you had an abnormal Pap test result?	☐ Yes	☐ No	☐ Do not know
Have you been tested for Human Papillomavirus (HPV)?	☐ Yes	☐ No	☐ Do not know
↳If YES: Approximately when was your last HPV test:			
Have you had a hysterectomy (removal of the womb or uterus)?	☐ Yes	☐ No	☐ Do not know
↳If YES: was the hysterectomy done due to cervical cancer?	☐ Yes	☐ No	☐ Do not know
If you are a current/former smoker, how long has it been since you last smoked commercial tobacco?	☐ Don't smoke ☐ Within 1 week ☐ Within 1 month ☐ Within 1 year	☐ 1-5 years ago ☐ 5-10 years ago ☐ Over 10 years ago	
If you smoke commercial tobacco, would you like help to quit?	☐ Yes	☐ No	☐ Not applicable
Does anyone else in your household smoke?	☐ Yes	☐ No	

For Clinic Staff

Does the client meet all the eligibility criteria?

☐ Yes (If yes, assign enrollment number and date) ☐ No

Enrollment #: Enrollment Date:

Enrollment #: _____

Program Description

The American Indian Cancer Foundation (AICAF) recognizes the large health disparities American Indian and Alaska Native people (AI/AN) face. The Screen Our Circle program aims to increase the availability of breast and cervical cancer screening. The purpose of screening is to detect cancer in its earliest stage so it can be treated or cured. Screening for breast cancer includes a clinical breast examination and a mammogram. Screening for cervical cancer includes a pelvic examination, Pap test and HPV test, if appropriate.

You will be provided the following services at no cost through Screen Our Circle if you are determined to be eligible:

- Screening, diagnostic and client navigation services
- If treatment is needed, a special program may be available to you at no cost

For more information about Screen Our Circle, contact the Program Manager.

Permission for Release of Information

- I understand that by completing the Client Eligibility, Enrollment, and Consent & Release Form, I will be enrolled and my doctors and health care providers will be paid for eligible services
- In this document, "my doctors and health care providers" means any doctor or other health care provider who delivers health care services to me at any time between my first visit and one year after the date of my signature below
- I give permission for my doctors and health care providers to release the following information to Screen Our Circle staff:
  - All information I provide on the Client Eligibility Form and Client Enrollment Form
  - The names, addresses and phone numbers of my doctors and health care providers
  - My chart number and all information about any breast and cervical cancer screening and follow-up tests
- I give permission to the Screen Our Circle program to give information to my doctors and health care providers from Screen Our Circle forms
- I give permission for the Screen Our Circle program to give information to partner organizations (e.g. state cancer registries)
- I understand that AICAF will use this information to determine whether I meet eligibility requirements and to assure I receive the appropriate screening tests and follow-up care or treatment
- Information given to AICAF will be protected under HIPAA. AICAF will keep my identity private, which means that the only people having access to identifying information will be my doctors and health care providers, AICAF employees, and contractors who work with AICAF. Information is also shared with the CDC but does not include my name or street address. Information that AICAF releases to my doctors and health care providers will be protected by federal or state medical privacy rules
- I am not required by law to provide any information to AICAF. If I do not provide the requested information (except for my Social Security number) I might not be able to participate in the program. I do not need to provide my Social Security number
- I understand that my participation is voluntary and I may withdraw and cancel my permission at any time. In order to cancel my permission, I need to send a letter to my doctors and health care providers and to Screen Our Circle. The letter must include my name, date of birth, a statement that my permission to release my information is canceled, my signature and date of release
- I understand that if I cancel my permission, I will no longer be enrolled and may be financially responsible for any outstanding bills from my doctors and health care providers
- My consent for enrollment expires one year from the date of my signature
- I understand that I will need to enroll in Screen Our Circle yearly

*By signing and dating below, I agree and understand to all the items above.

Client Name (printed):	Birth Date: MM/DD/YYYY
Client Signature:	Signature Date: MM/DD/YYYY