Print Reset form

PUBLIC HEALTH DIVISION
ScreenWise Program

Oregon Health Authority

ScreenWise Patient Intake Packet

Due to ScreenWise within 5 days of enrollment

Enrolling agency: _____ Site name: _____

Enrollment type: ☐ In person (*signature required*) ☐ Remotely (*indicate 'remote' on signature line*)

Medical record number: _____ Date of enrollment: _____

Patient full name: _____ Date of birth: _____

Gender identity (such as female, male or non-binary): _____

☐ Homeless or unstable housing? (*If so, check box and only write ZIP code and county below*)

Home address: _____ Apartment number: _____

City: _____ State: _____ Zip code: _____

Phone: _____ County: _____

Do you have health insurance or Medicaid?

☐ Yes
☐ Yes, but not enough to cover my needs
☐ No

What is your gross monthly household income?
(*This is the total income before taxes for all household members*) $ _____ monthly

How many people live in your household?
(*Including yourself*) _____ people

Patient consent

The Oregon ScreenWise program (*ScreenWise*), a program of the Oregon Health Authority, aims to reduce breast and cervical cancer, by promoting prevention and early detection.

ScreenWise may pay for:

- Screening and diagnostics for breast or cervical cancer
- Patient navigation and support

ScreenWise will not pay for breast or cervical cancer treatment. If treatment is needed, patients may apply for the Medicaid Breast and Cervical Cancer Treatment Program (BCCTP).

By signing this form, I **understand** that:

- My enrollment may start up to three months before the date signed below, allowing ScreenWise to pay for eligible claims during that period.
- I will remain enrolled in ScreenWise for one year while I am still eligible and do not ask to be taken out of the program.

- My provider will assess my eligibility to remain in the program every year.
- ScreenWise, my medical care providers, clinics and/or hospitals may share information with one another about my health care and any related medical care I receive through ScreenWise; and may organize my care and involvement in appropriate screening and/or diagnostic services, related to breast and cervical cancer.
- My information will not be shared with anyone outside of the Oregon Health Authority, its contracted providers and funders; and any published report will not use my name.
- I may receive written, telephone or electronic communications related to ScreenWise services.
- My provider must tell me in writing about any services that are not covered by ScreenWise.

By signing this form, I **confirm** that:

- I meet all of the following eligibility requirements for the program:
  - ✓ I live in or intend to live in Oregon
  - ✓ My household income is at or below 250% of the Federal Poverty Level
  - ✓ I do not have insurance, or my insurance does not fully cover my needs

Patient signature: _____ Date: _____

Patient name (*printed*): _____

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact ScreenWise Program at screenwise.info@odhsoha.oregon.gov or 1-877-255-7070 (voice/text). We accept all relay calls.

Patient service eligibility

Does the patient need breast or cervical cancer diagnostic services?

- ☐ 18-39 years old*
- ☐ 40 years or older

*Patients 18-39 are not eligible for enrollment unless diagnostic services are needed

Breast cancer assessment *selections do not affect eligibility*

High risk for breast cancer? ☐ Yes ☐ No ☐ Unknown

Breast cancer services

CBE date: _____ (*MM/DD/YYYY*)

- ☐ Normal exam/benign finding
- ☐ Abnormal/suspicious for cancer
- ☐ Not performed

- ☐ Yes (*screening or diagnostic*)
- ☐ No (*screening or diagnostic*)
- ☐ Sent directly for additional diagnostics (*e.g. ultrasound, biopsy, etc.*)

Cervical cancer assessment *selections do not affect eligibility*

Last Pap (prior to current enrollment)?

- ☐ Yes, date (*if known*): _____ (*MM/DD/YYYY*)
- ☐ No
- ☐ Unknown

High risk for cervical cancer? ☐ Yes ☐ No ☐ Unknown

Cervical cancer screening services

Current Cervical Services ordered: _____ (*MM/DD/YYYY*)

- ☐ Routine Pap
- ☐ Surveillance after recent abnormal Pap
- ☐ No pap, other diagnostics ordered
- ☐ Colposcopy
- ☐ Other cervical diagnostics
- ☐ No cervical services performed

HPV ordered? ☐ Yes ☐ No

Oregon Health Authority

Race, Ethnicity, Language and Disability (REALD)

(To be completed by patient)

These questions are optional, and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences. If you do not want to answer these questions, please check, "Don't want to answer." If you have any questions when filling out this form, please ask clinic staff for help.

Race and ethnicity

1. How do you identify your race or ethnicity, tribal affiliation, country of origin, or ancestry? (*for example, your parents' ancestry, tribal membership*)

   _____

   ☐ Don't want to answer

2. Which of the following describes your racial or ethnic identity? Please check **ALL** that apply.

Hispanic and Latino/a/x

- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Hispanic and Latino/a/x

- ☐ Chamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White

- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African

- ☐ Middle Eastern
- ☐ North African

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories

- ☐ Other, please list:

  _____

- ☐ Don't know
- ☐ Don't want to answer

3. If you checked more than one category above, is there one you think of as your primary racial identity?
   - ☐ Yes. Please circle your primary racial or ethnic identity above.
   - ☐ I do not have just one primary racial or ethnic identity.
   - ☐ No. I identify as Biracial or Multiracial.
   - ☐ N/A. I only checked one category above.
   - ☐ Don't know
   - ☐ Don't want to answer

Language (*Interpreters are available at no charge*)

4a. What language or languages do you use at home?

_____

Skip to question 7 if you did NOT indicate a language other than English or sign language

4b. In what language do you want us to communicate in person, on the phone, or virtually with you?

_____

4c. In what language do you want us to write to you?

_____

5a. Do you need or want an interpreter for us to communicate with you?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

- ☐ Spoken language interpreter
- ☐ American Sign Language (ASL) interpreter
- ☐ Deaf interpreter for DeafBlind and with additional barriers
- ☐ Contact sign language (PSE) interpreter
- ☐ Other (*please list*): _____

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?
   - ☐ Very well
   - ☐ Well
   - ☐ Not well
   - ☐ Not at all
   - ☐ Don't know
   - ☐ Don't want to answer

Disability/ability level

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential.

7. Are you deaf or do you have serious difficulty hearing?
   ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
   If yes, at what age did this condition begin? _____

8. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
   ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
   If yes, at what age did this condition begin? _____

Please stop now if you/the person is under age 5

9. Do you have serious difficulty walking or climbing stairs?
   ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
   If yes, at what age did this condition begin? _____

10. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
    ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
    If yes, at what age did this condition begin? _____

11. Do you have serious difficulty dressing or bathing?
    ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
    If yes, at what age did this condition begin? _____

12. Do you have serious difficulty learning how to do things most people your age can learn?
    ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
    If yes, at what age did this condition begin? _____

13. Using your usual (*customary*) language, do you have serious difficulty communicating, (*for example understanding or being understood by others*)
    ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
    If yes, at what age did this condition begin? _____

Please stop now if you/the person is under age 15

14. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
    ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
    If yes, at what age did this condition begin? _____

15. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?
    ☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
    If yes, at what age did this condition begin? _____