Client Agreement

Section 1:

I have received the income guidelines. I have not supplied documentation of household income. I declare my household income meets Missouri Screen for Life's present income guidelines.

Your initials ______

Section 2:

I understand I *may* qualify for Missouri Screen for Life.

If I qualify, I understand...

- Missouri Screen for Life services will be available to me for free.
- My health is my responsibility. I am responsible for keeping my appointments.
- Missouri Screen for Life staff may contact me about scheduling certain medical services.
- No medical test is 100% accurate.

Even if I do not qualify...

- Missouri Screen for Life staff may contact me about referring certain medical services if my health history shows that I need medical attention.

As a client receiving services funded by Missouri Screen for Life, I agree that I have been given a copy of the "***Missouri Department of Health and Senior Services Notice of Disclosure,***" which also tells me where I can obtain updates.

______________________________ ____/____/____

Signature of Client/Parent/Guardian/ Durable Power of Attorney for Health Care (DPOA-HC) *Date*

If signature other than that of client, please print name and indicate relationship:

______________________________ ______________

Name *Relationship*

You must have a witness sign this form to show that you received the Notice of Disclosure.

______________________________ ____/____/____

Witness Signature *Date*

Mail this completed form to:
St. Louis ConnectCare, ATTN: Robin Snider
5535 Delmar Blvd, St. Louis, MO 63112
Telephone (314) 879-6392

Missouri Screen for Life
Colorectal Cancer Screening Demonstration Program

Funded by the Centers for Disease Control and Prevention

ELIGIBILITY: Do you qualify for Missouri Screen for Life?

To find out, answer the questions below.

1. Do you live in St. Louis City, St. Louis County, Franklin County, Jefferson County, or St. Charles County? **YES** **NO**

2. **For people age 49 and younger:** Do you have a personal history of polyps or colon cancer or a family history of colon cancer? **For people age 50 and older:** Are you 50- 64 years old? **YES** **NO**

3. Do you meet the income guidelines of Missouri Screen for Life? ***(see table below)*** **YES** **NO**

Directions for income guidelines:

a. How many people are in your household? Find this number in the blue column and circle it.

*b. Look at the numbers in the yellow row to the right of your circled number. Does your household earn **this amount** or **less than this amount** each year, month, week, or hour? If so, circle yes.*

INCOME GUIDELINES FOR MISSOURI SCREEN FOR LIFE

Size of household	Income per year	Income per month	Income per week	Income hourly
1	**$19,600**	$1,633.00	$377.00	$9.42
2	**$26,400**	$2,200.00	$508.00	$12.69
3	**$33,200**	$2,767.00	$638.00	$15.96
4	**$40,000**	$3,334.00	$769.00	$19.23
5	**$46,800**	$3,900.00	$900.00	$22.50
6	**$53,600**	$4,467.00	$1,031.00	$25.77
7	**$60,400**	$5,033.00	$1,162.00	$29.04
8	**$67,200**	$5,600.00	$1,292.00	$32.31
Each additional person, add:	**$6,800**	$567.00	$131.00	$3.27

Did you circle "No?"
You do not qualify for Missouri Screen for Life.

Did you circle "Yes" for *every* question?
You may qualify for Missouri Screen for Life. Please continue to next page. →

A. Personal History

Name (Last, First, Middle Initial)

Maiden name (if applicable)

Date Of Birth (MM/DD/YYYY) ____ /____ /_______

Social Security Number _____ - ___ - ________

Street address

City

State

ZIP code

County

Home phone or number where you can be reached (include area code)

(________) _________ - __________________

Work phone (include area code)

(________) _________ - __________________

Number of household members ___________

Household income (monthly) $_______________

Today's date (MM/DD/YYYY) ____ /____ /_______

Insurance
☐ Medicaid ☐ Medicare
☐ None ☐ Private

Medicaid DCN:

Gender:
☐ Male
☐ Female
☐ Other/Unknown

Hispanic or Latino origin: *(Client must answer)*
☐ Yes ☐ No ☐ Unknown/Missing

Race: *(Choose all that apply)*
☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Other:(specify) _______________
☐ Unknown

Highest grade of school completed *(circle one)*
(OR U.S. equivalent if educated in another nation)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

How did you hear about the program? *(Choose up to 3)*
☐ Doctor
☐ Health care provider
☐ Show Me Healthy Women program
☐ Family member
☐ Friend
☐ Radio
☐ Television
☐ Magazine article
☐ Newspaper
☐ Mailing/Flyer
☐ Community event
☐ Clinic
☐ Printed ad
☐ Billboard
☐ Bus sign
☐ Health fair
☐ Health coalition
☐ Outreach worker
☐ Extension service
☐ Workforce development
☐ Other *(specify)*: _______________

What type of transportation did you use to get to your appointment?
☐ Bus
☐ ACT Van
☐ OATS Bus
☐ Taxi
☐ Personal Vehicle
☐ Relative/Friend
☐ SMTS
☐ Other (specify)_______________

Have you smoked at least 100 cigarettes in your entire life?
☐ Yes ☐ No

Do you now smoke cigarettes every day, some days, or not at all?
☐ Every day ☐ Not at all ☐ Refused
☐ Some days ☐ Don't know/ not sure

Do you presently have any of the following symptoms?
1) Blood *(either bright red or very dark)* in the stool? ☐ Yes ☐ No
2) Significant weight loss with no known reason? ☐ Yes ☐ No

CLINICAL STAFF ONLY:
Referring provider: ______________________________ Eligibility verified by staff: Yes No

B. Colon Cancer Health History (Check ☑ all that apply)

Have you had any of the following colon cancer screening tests?

Stool Test (FOBT/FIT):
☐ Yes → *If yes, Date of test, MM/YYYY* ______/________
Result of last stool test: ☐ Normal ☐ Abnormal ☐ Unknown
☐ No ☐ Unknown *(Go to next question)*

Sigmoidoscopy:
☐ Yes → *If yes, Date of test, MM/YYYY* ______/________
Result of last sigmoidoscopy: ☐ Normal ☐ Abnormal ☐ Incomplete ☐ Unknown
☐ No ☐ Unknown *(Go to next question)*

Colonoscopy:
☐ Yes → *If yes, Date of test, MM/YYYY* ______/________
Result of last colonoscopy: ☐ Normal ☐ Abnormal ☐ Incomplete ☐ Unknown
☐ No ☐ Unknown *(Go to next question)*

Double-Contrast Barium Enema (DCBE):
☐ Yes → *If yes, Date of test, MM/YYYY* ______/________
Result of last DCBE: ☐ Normal ☐ Abnormal ☐ Incomplete ☐ Unknown
☐ No ☐ Unknown *(Go to green section)*

Do you have a personal history of polyps?
☐ Yes ☐ No ☐ Unknown
Year diagnosed: _____________
Largest number of polyps diagnosed during single procedure *(if not sure, provide estimate)*: _________
Is this an exact number or estimate?
☐ Exact ☐ Estimate
Were any polyps adenomatous (pre-cancerous)?
☐ Yes ☐ No ☐ Unknown

Have you ever been diagnosed with any of the following conditions?
☐ Chronic ulcerative colitis
☐ Crohn's disease
☐ Genetic syndromes (HNPCC or FAP)

Have you been diagnosed with colon cancer?
☐ Yes ☐ No ☐ Unknown
Year diagnosed: _______________

Have family members been diagnosed with colon cancer or colon polyps?
☐ Yes ☐ No ☐ Unknown
List which relative(s), the number of each relative(s) if more than one, and their age at diagnosis:

☐ Mother age: _____
☐ Father age: _____
☐ Brothers # _____ ages: _______
☐ Sisters # _____ ages: _______
☐ Sons # _____ ages: _______
☐ Daughters # _____ ages: _______
☐ Grandmothers # _____ ages: _______
☐ Grandfathers # _____ ages: _______
☐ Grandchildren # _____ ages: _______
☐ Aunts # _____ ages: _______
☐ Uncles # _____ ages: _______
☐ Cousins # _____ ages: _______

Do you have diabetes?
☐ Yes ☐ No ☐ Unknown
Do you take insulin? ☐ Yes ☐ No

(WOMEN ONLY) ***Have you been diagnosed with uterine or ovarian cancer?***
☐ Yes ☐ No
Your age when diagnosed: ____

CLINICAL STAFF ONLY:

Medical Eligibility Status
☐ Eligible
☐ Medical Conditions
☐ Recently Screened

Date medical eligibility determined:
____ / ____ / _______
MM DD YYYY

Client Risk Factor Questionnaire assessment:
☐ Average Risk
☐ High Risk

Initial test recommended:
☐ Fecal Occult Blood Test (average risk only) (FOBT Hemocult II - take home or mailed)
☐ Colonoscopy (high risk only)
☐ DCBE (only following incomplete colonoscopy)