Dartmouth-Hitchcock Medical Center
NHCRCSP
One Medical Center Drive
Lebanon, NH 03756-0001
Phone (603) 653-3702
Fax (603) 727-7798
www.cancer.dartmouth.edu/NHCRCSP

Dear Potential Client,

Thank you for your interest in colorectal cancer screening. Dartmouth-Hitchcock in collaboration with the New Hampshire Department of Health and Human Services (NHDHHS) has implemented the New Hampshire Colorectal Cancer Screening Program (NHCRCSP), a statewide effort to increase colorectal cancer (CRC) screening for NH residents. The program will also provide a limited number of free colonoscopies to men and women who are New Hampshire residents and who meet financial and clinical eligibility for the screening program.

Enclosed is information about the early detection of cancer, Client Enrollment Information, an NHCRCSP Enrollment Form, a Consent For Participation in the NHCRCSP Form, an Authorization for Use/Disclosure of Protected Health Information Form, and a business reply envelope. Please follow the instructions contained in the Client Enrollment Information "Next Steps" section to be considered for the free colonoscopy part of the program.

If you have any questions please call us at (603) 653-3702. Again thank you for your interest in the program.

Sincerely,

NHCRCSP

Enclosures:
Brochure
NHCRCSP Client Enrollment Information
FORM A, NHCRCSP Enrollment Form
FORM B, Consent For Participation in the NHCRCSP Form (2)
FORM C, Authorization for Use/Disclosure of Protected Health Information Form (2)
Business Reply Envelope

Dartmouth-Hitchcock

New Hampshire Colorectal Cancer Screening Program (NHCRCSP)
Client Enrollment Information

What is the New Hampshire Colorectal Cancer Screening Program (NHCRCSP)?
Dartmouth-Hitchcock in collaboration with the New Hampshire Department of Health and Human Services (NHDHHS) has developed the New Hampshire Colorectal Cancer Screening Program (NHCRCSP), a statewide effort to increase colorectal cancer screening for NH residents.

Who is funding the NHCRCSP?
The NHCRCSP is funded from the Centers for Disease Control (CDC) with in-kind donations from Dartmouth-Hitchcock, Dartmouth-Hitchcock's Norris Cotton Cancer Center, NHDHHS, and others. In order to carry out the program there are eligibility guidelines, both clinical and financial. Not everyone who completes the forms will be eligible.

If I am enrolled into the NHCRCSP what services will I receive?
As a client of NHCRCSP, you have access to free education on colorectal cancer screening, a free colonoscopy screening test and free patient navigation services to assist you with obtaining the test and the preparation for the test.

What services are not covered by the NHCRCSP?
If enrolled in the program, your free colonoscopy can find polyps or cancer. If your colonoscopy finds polyps they may be removed during the procedure. If cancer is found and further treatment or testing is needed, the NHCRCSP cannot pay for these services but will provide you with a timely and appropriate referral to obtain these services.

Who is eligible for the colonoscopy screening services of the NHCRCSP?
You must meet all of the following criteria to be eligible for the screening program:

- Men and women who are 50-64 years of age.
- Average Risk for colon cancer – People who have symptoms suggestive of gastrointestinal disease, inflammatory bowel disease (Crohn's Disease or Ulcerative Colitis), or evidence of genetic syndromes associated with colorectal cancer cannot be enrolled in the program.
- Individuals with a personal or family history of colorectal cancer or polyps will be considered.
- Uninsured or underinsured. Underinsured is defined as having at least a $500 deductible, co pay or co insurance.
- Eligible individuals will be at or below 250% of federal income guidelines. Both uninsured and underinsured must meet these income guidelines
- Reside in New Hampshire.
- Be medically cleared by a primary care provider/physician for a colonoscopy (the program will assist you in doing this if needed).

How do I register in the NHCRCSP?

You must complete an enrollment form each time you would like to be screened, and follow the "Next steps" mentioned below.

Next steps to enroll in the NHCRCSP:

- ☐ Read the Colorectal Cancer Screening brochure
- ☐ Complete both sides (front and back) of **Form A** (the registration form).
- ☐ Read and sign the **Form B**, the consent for participation in the NHCRCSP. Plan to send a copy of this document to NHCRCSP and keep one for your own file.
- ☐ Please read and complete the **Form C,** the authorization for the use / disclosure of protected health information, by placing the name of your family doctor where indicated. Plan to send a copy of this document to NHCRCSP and keep one for your own file.
- ☐ Mail your complete package (forms A, B and C) to:

  Dartmouth-Hitchcock Medical Center
  NHCRCSP
  One Medical Center Drive
  Lebanon, NH 03756 - 0001
- ☐ Your **completed** forms will be reviewed by NHCRCSP staff, who will only contact you at this point in the process if they have further questions.
- ☐ Your doctor will then contacted to ensure that it is safe and appropriate for you to have a colonoscopy. If you don't have a primary care physician or have not seen a PCP in the last year, you will be assisted by the NHCRCSP staff in scheduling a visit. The visit will be paid by the NHCRCSP.
- ☐ If you are accepted into the program, the NHCRCSP staff will notify you of your registration by mail.
- ☐ After enrollment, a NHCRCSP colonoscopy site will contact you to schedule the procedure.
- ☐ If you need more registration forms for other people in your home or for friends or family members who meet the eligibility guidelines, please call the NHCRCSP Office at (603) 653-3702.

2015 Current Federal Poverty Income Level Guidelines

In January of each year, the federal government releases the Federal Poverty Income Guidelines. To be eligible for the New Hampshire Colorectal Cancer Screening Program your income (before taxes are deducted) must fall at or below 250% of this guideline. The numbers listed below are 250% of the guideline income levels. A pregnant woman counts as two for the purpose of this calculation.

2015 Current 250% Federal Poverty Guidelines		
Family Size	**250% Gross Yearly Income**	**250% Gross Monthly Income**
1	**$29,425**	**$2,452**
2	**$39,825**	**$3,320**
3	**$50,225**	**$4,185**
4	**$60,625**	**$5,052**
5	**$71,025**	**$5,920**
6	**$81,425**	**$6,785**
7	**$91,825**	**$7,652**
8	**$102,225**	**$8,520**

Form A – Enrollment Form
New Hampshire Colorectal Cancer Screening Program (NHCRCSP)

TO BE COMPLETED BY PATIENT – PLEASE PRINT AND COMPLETE BOTH SIDES

Name: _____ _____ _____ _____
(Last) (First) (MI) (Maiden)

Date of Birth (Month/Day/Year): __ __ / __ __ / __ __ __ __ Gender: ☐ Male ☐ Female

Address: _____ County of Residence: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ - _____

Other Phone Number: (_____) _____ - _____ Email Address: _____

Can we use this email address to contact you? ☐ Yes ☐ No Preferred Contact Time? _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

NAME OF PERSON IN THE EVENT WE ARE UNABLE TO REACH YOU

Name: _____ Relationship to You: _____

Phone Number: (_____) _____ - _____

DEMOGRAPHIC INFORMATION

Do you have any needs or disabilities of which we should be aware? ☐ No ☐ Yes, Check all that apply
☐ Hearing Impairment ☐ Speech Impairment ☐ Need help making appointments ☐ Handicap Access
☐ Learning Disability ☐ Need help filling out forms ☐ Other, specify: _____
Race (Check all that apply): ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian or Alaskan
☐ Unknown
Are you of Hispanic origin? ☐ Yes ☐ No
Primary Language: ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other, specify: _____
Is an interpreter needed? ☐ Yes ☐ No
How much is your yearly, household gross income? $_____
Number of people (including yourself) who are supported by this income: _____
Education (highest level): ☐ No High School ☐ Some High School ☐ High School Graduate or equivalent
☐ Some college or higher ☐ Don't Know ☐ Prefer not to answer
Marital Status: ☐ Married ☐ Never Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Living with someone
Do you have health insurance? ☐ Yes ☐ No, if no, are you eligible for Medicaid? ☐ Yes ☐ No
If you have health insurance, please tell us what kind: ☐ Medicare: ☐ Part A ☐ Part B ☐ Medicaid
☐ Private Insurance (such as Anthem or Blue Cross) If private, name: _____
If you have insurance, what is the total amount of your deductible for a colonoscopy? $ _____

FAMILY HEALTH PROVIDER/DOCTOR

Do you have a primary care provider or family doctor? ☐ No ☐ Yes, if yes, please complete the following:

Name of Provider: _____ Name of office or practice: _____

Phone Number: (_____) _____ - _____ Fax: (_____) _____ - _____

Address: _____

City: _____ State: _____ Month/Year of last visit: __ __ / __ __ __ __

Turn over to complete page 2

CANCER SCREENING HISTORY

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

Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) in the PAST YEAR?

☐ No ☐ Yes, if yes was your test: ☐ Positive or ☐ Negative

Colonoscopy? ☐ No ☐ Yes, if yes, please tell us the year of your last test and name of facility where test was done.

Year: __ __ __ __ Facility: _____

Were there polyps? ☐ No ☐ Don't Know ☐ Yes

If yes, were you told that any of the polyps were "precancerous"? ☐ No ☐ Don't Know ☐ Yes

Sigmoidoscopy in the last five years? ☐ No ☐ Yes, if yes, please tell us the year of your last test and name of facility where test was done. Year: __ __ __ __ Facility: _____

CANCER HISTORY

Have you ever had colon or rectal cancer? ☐ No ☐ Yes

Have you ever had other types of cancers? ☐ No ☐ Yes, if Yes, type of cancer? _____

Have any family members had colorectal cancer? ☐ No ☐ Don't Know ☐ Yes

If yes, please list relationship to you and age at diagnosis of the colorectal cancer.

Relationship: _____ Age at Diagnosis: _____

Relationship: _____ Age at Diagnosis: _____

Relationship: _____ Age at Diagnosis: _____

Have any family members had colorectal polyps? ☐No ☐Don't Know ☐Yes, list relationship to you and age found

Relationship: _____ Age Found: _____

Have any family members had other types of cancer? ☐No ☐Don't Know ☐Yes, if yes, type of cancer(s)?

_____

HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE ANY OF THE FOLLOWING?

Inflammatory Bowel Disease (IBD) (Crohn's Disease or Ulcerative Colitis)	☐Yes	☐No	☐Don't Know
Familial Adenomatous Polyposis (FAP)	☐Yes	☐No	☐Don't Know
Hereditary Non Polyposis Colorectal Cancer (HNPCC)	☐Yes	☐No	☐Don't Know
SIGNIFICANT bleeding from your rectum or bloody stools?	☐Yes	☐No	
RECENT NEW diarrhea or constipation lasting more than 2 weeks?	☐Yes	☐No	
Unexplained weight loss of more than 10% of your body weight?	☐Yes	☐No	

MEDICAL HISTORY

Weight (Pounds): _____

Do you take any blood thinners such as Coumadin or Plavix?	☐Yes	☐No
Do you have any bleeding disorders (difficulty getting your blood to clot)?	☐Yes	☐No
Are you taking daily prescription pain medications?	☐Yes	☐No
Do you use daily supplemental oxygen or a C-Pap Machine?	☐Yes	☐No
Are you aware of any problems with sedation or anesthesia?	☐Yes	☐No
Do you have any allergies to medications or latex?	☐Yes	☐No
If yes, please tell us what your allergies are: _____		
Do you have a pacemaker or defibrillator device?	☐Yes	☐No
Are you a diabetic?	☐Yes	☐No
If yes, do you take any medications for this?	☐Yes	☐No
Would you consider yourself in good health?	☐Yes	☐No
If no, please list your medical problems: _____		
Are you a current smoker?	☐Yes	☐No

How did you hear about the program? ☐Brochure/Poster ☐Mailing (Specify) _____

☐Healthcare Professional (Specify) _____ ☐Friends / Family

☐ TV / Radio / Newspaper (Specify name): _____ ☐ Other (Specify): _____

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FORM B
New Hampshire Colorectal Cancer Screening Program (NHCRCSP)
Consent for Participation in the NHCRCSP

Please read and sign this form to be considered for enrollment in the NHCRCSP. In addition, you will need to sign an authorization for use/disclosure of protected information. Please keep the additional copies for your records.

I want to be a part of the New Hampshire Colorectal Cancer Screening Program (NHCRCSP). I understand that I must meet clinical and financial eligibility for enrollment. If not eligible I will be referred to other resources.

I understand that I need to identify a primary care doctor/provider on my enrollment form. I must have had a primary care visit with a healthcare provider within the last year. The attached authorization for use/disclosure of protected information form will allow the NHCRCSP to obtain medical information from my healthcare provider. If I have not had a primary care visit within the last year the NHCRCSP will pay for and assist with arranging for this visit.

If I am enrolled in the program I will receive a free colonoscopy through the NHCRCSP. I understand that the colonoscopy is a screening colonoscopy and could find polyps or cancer. As a result of this test I might need more tests or treatment. If I do need more tests or treatment they will not be paid for by this program. A NHCRCSP staff person will help me find timely and appropriate care if I need further tests or treatment.

To assist me in making the best healthcare decisions, NHCRCSP may share clinical and other healthcare information with my healthcare providers.

My name, address, and/or other personal information will be used only by the NHCRCSP. It may be used to let me know when I need follow up exams or may be shared with other organizations as required to locate treatment resources.

I also authorize the NHCRSP to share my information with the Centers for Disease Control and Prevention for quality assurance, quality control, and studies to learn more about colon cancer. My name or personal information will not be used.

I know that I can ask for a copy of my NHCRCSP records at anytime and I can take back the consent for participation in the NHCRCSP at any time by writing to the NHCRSP at NHCRCSP, One Medical Center Drive, Lebanon, NH 03756.

Please Print Name: _____ Date: _____

Signature: _____

Dartmouth-Hitchcock

FORM C
AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)
All sections of this form must be filled out completely or it will not be accepted.

I hereby authorize _____
(Fill in name of Primary Care Provider)

to use/disclose my individually identifiable health information as described below (which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations.

Patient Name: _____ DOB: _____

Address: _____ Phone Number: _____

The purpose of the use and/or disclosure is to obtain information that will allow the NHCRCSP to identify my risk for colorectal cancer and to identify my risk for undergoing a colonoscopy. All relevant inpatient and outpatient information can be disclosed to DHMC, NHCRCSP, One Medical Center Drive, Lebanon, NH 03756.
This information may include: Discharge Summaries, Operative Records, Laboratory Report/Test Results, Consultation Reports, Progress Notes, Ambulatory Care Notes, and Emergency Department Reports.

I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify. (Alternative date if desired): _____.

I further understand that I may revoke this authorization at any time by notifying the above named Primary Care Provider, except to the extent it has already been relied upon.

_____ _____ _____
Signature of Patient or Personal Representative Phone Number

_____ _____
Printed Name of Patient or Personal Representative Date

5/29/14*Two copies in Enrollment Packet because one is a client copy, the other is the NHCRCSP copy