EWM Diagnostic Program - Cervical

-How EWM can help your clients with abnormal Pap tests

-What your office needs to do

EVERY WOMAN MATTERS

EWM Diagnostic Program - Cervical

Who can enroll?*

Diagnostic Enrollment is for women with abnormal Pap tests or visible cervical lesions suspicious for cervical cancer within the last 6 months who are in need of further testing to diagnose whether or not **cervical cancer** is present.

Not for women with abnormal bleeding, endometriosis, or to diagnose any other gynecological cancer or condition.

*If your client needs a Pap test, please see our EWM Screening Guidelines for instructions.

Who can enroll in the EWM Diagnostic Cervical Program?

EWM Cervical Diagnostic Program Eligibility	
Age:	21-74 years old
Income:	Must meet income guidelines (see slide 16 for details)
Insurance:	• **Women with insurance are eligible for the EWM Diagnostic program** (but ineligible for screening). See slide 9. • Uninsured women are eligible for the diagnostic program as well.
Citizenship:	Must be US Citizen or Permanent Resident (See slide 15)
Health Status:	Must have had abnormal cervical screening and in need of services to diagnose whether or not cervical cancer is present

What EWM covers– cervical services

Depends on results of Pap test:

- Colposcopies
- Endometrial biopsies ONLY FOR THOSE WITH AGC PAP
- Consultations

What EWM covers depends on Pap test result, HPV result, age of client

Co-Testing	HPV	Unsatisfactory	HPV- AS-CUS / LSIL	HPV 16/18 AS-CUS / LSIL	HPV- ASC-H / HSIL	HPV 16/18 ASC-H / HSIL	AGC Any HPV result	Sq. Cell Carcinoma
Date___/___/___ ❍Negative Pap	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___
❍Cervical lesion ❍Colposcopy with biopsy DOS:____/____/____ **HPV+ Age 30-39** ❍Repeat co-testing in 1 year (must re-enroll in State Pap Program if under 40) **Age 40+** ❍If HPV 16 or 18 Colposcopy with biopsy DOS:____/____/____	**HPV+ Age 30-39** ❍Repeat HPV testing in 1 year (must re-enroll in State Pap Program if under 40) **Age 40+** ❍If HPV 16 or 18 Colposcopy with biopsy DOS:____/____/____	❍HPV unknown or HPV- Repeat cytology in 2-4 months (not eligible for colposcopy) **HPV+** **Ages 21-29** ❍Repeat cytology in 2-4 months *(no HPV test allowed per guidelines)* **Ages 30+** ❍Colposcopy with biopsy DOS: ____/____/____	**Ages 25-29** ❍Repeat HPV at 1 year **Ages 30-65** ❍Repeat co-testing at 1 year	❍Colposcopy w/ Biopsy (biopsy results <CIN2 5-year CIN 3 risk is 2.9% 1-year follow-up) DOS: ___/___/___ ❍Repeat HPV at 1 year interval ❍Repeat HPV at 3 year interval	❍Immediate diagnostic LEEP for Pap and colpo result discrepancy DOS: ___/___/___ ❍Repeat colposcopy in 1 year	❍Expedited Treatment or Colposcopy with biopsy Acceptable (25-59% CIN3 risk) DOS: ___/___/___ ❍Colposcopy with biopsy recommended (4-24% CIN 3 risk) ❍Immediate diagnostic LEEP for Pap and colpo discrepancy DOS: ___/___/___ ❍Repeat HPV test 6 months	**All Subcategories:** ❍Colposcopy with biopsy + ECC and ❍Endometrial biopsy* ❍Both to be done on the same day DOS: ___/___/___ **Atypical Endometrial Cells:** ❍Endometrial and endocervical sampling DOS: ___/___/___ **If no endometrial pathology:** ❍Colposcopy DOS: ___/___/___	❍Treatment referral to OB/GYN *Complete page 4: Cervical Cancer Treatment Section*

Services EWM does NOT cover

- Any gynecological procedure NOT due to abnormal pap
  - Post-menopausal bleeding
  - Abnormal periods
  - Abnormal discharge
  - Endometriosis
- Pelvic Ultrasounds
- CT scans
- Most other biopsies
- Cervical cancer treatment

Please Note: This is not an exhaustive list.

Enrolling Clients

- Clients never before enrolled in EWM
- Clients already enrolled in EWM

Who can enroll clients into EWM Cervical Diagnostic Program?

- **You can**! We'll show you how!
  - We call this process "enrolling clients diagnostically"
- Any EWM contracted provider can enroll clients diagnostically
- Clients do NOT have to be previously enrolled in the program

What if a client has insurance?

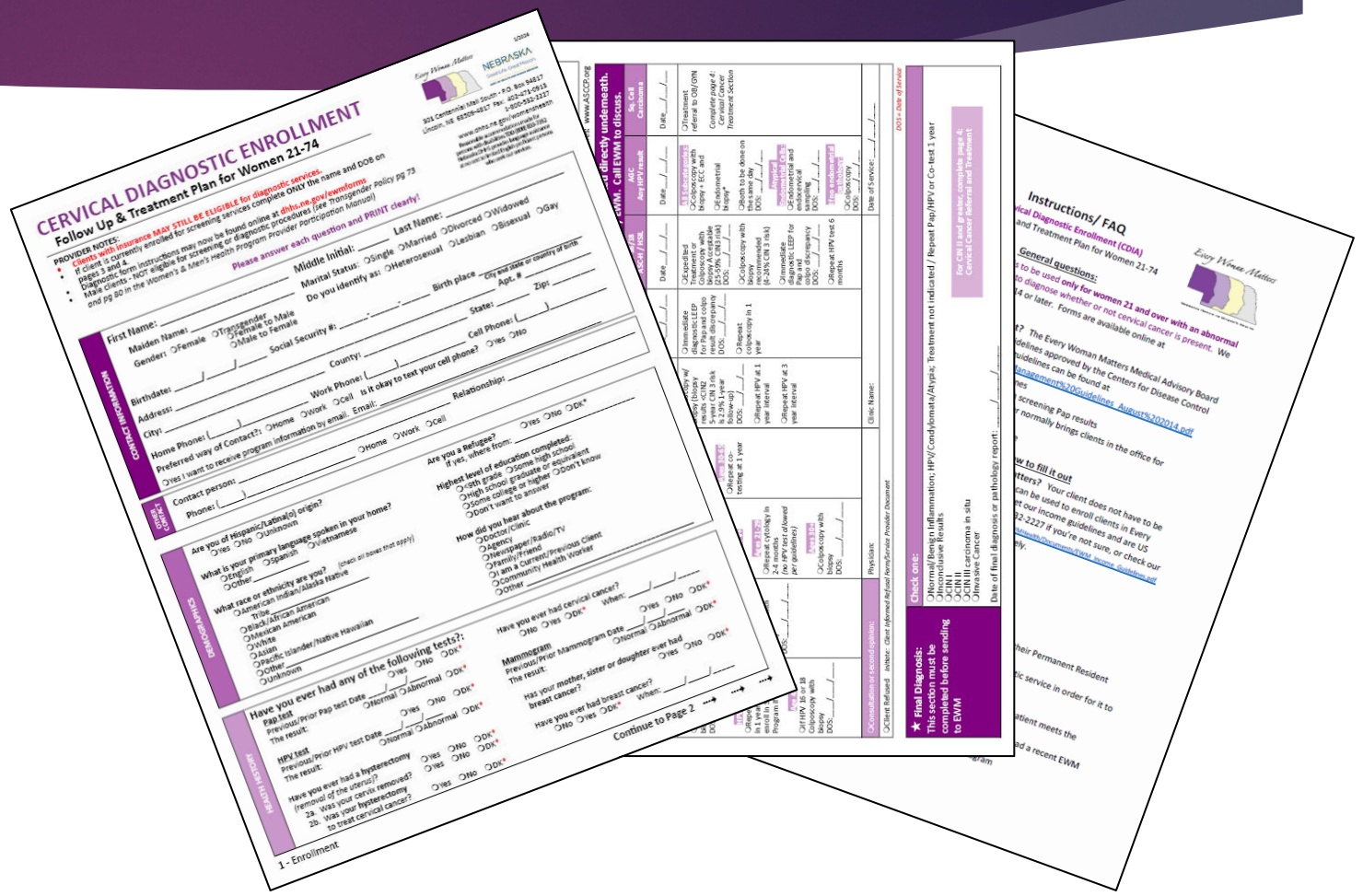
Many EWM Diagnostic clients have health insurance but still need our program to cover extra costs:

- Client is still eligible for the EWM Cervical Diagnostic Program
- Must meet all other program criteria
- Is not eligible for EWM Screening Program unless insurance does not pay for preventive services
- EWM will cover costs that insurance does not pick up
- Enroll her diagnostically

Having Health Insurance is OK!

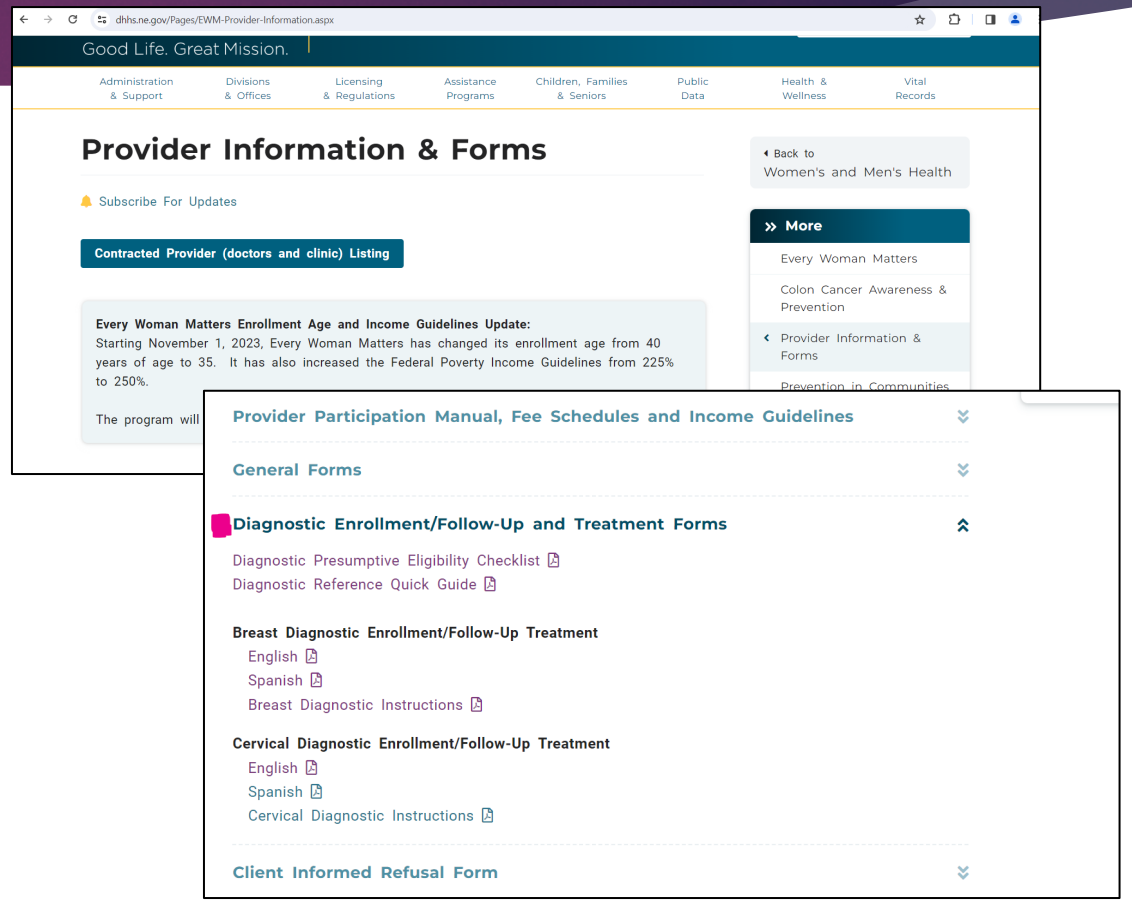
How do I enroll clients?

- Use the Cervical Diagnostic Enrollment form (CDIA)
- **Who/what is this form for?** This form is to be used ONLY for women with an **abnormal Pap test or abnormal cervical screening** or that are in need of further testing to diagnose whether or not cervical cancer is present.

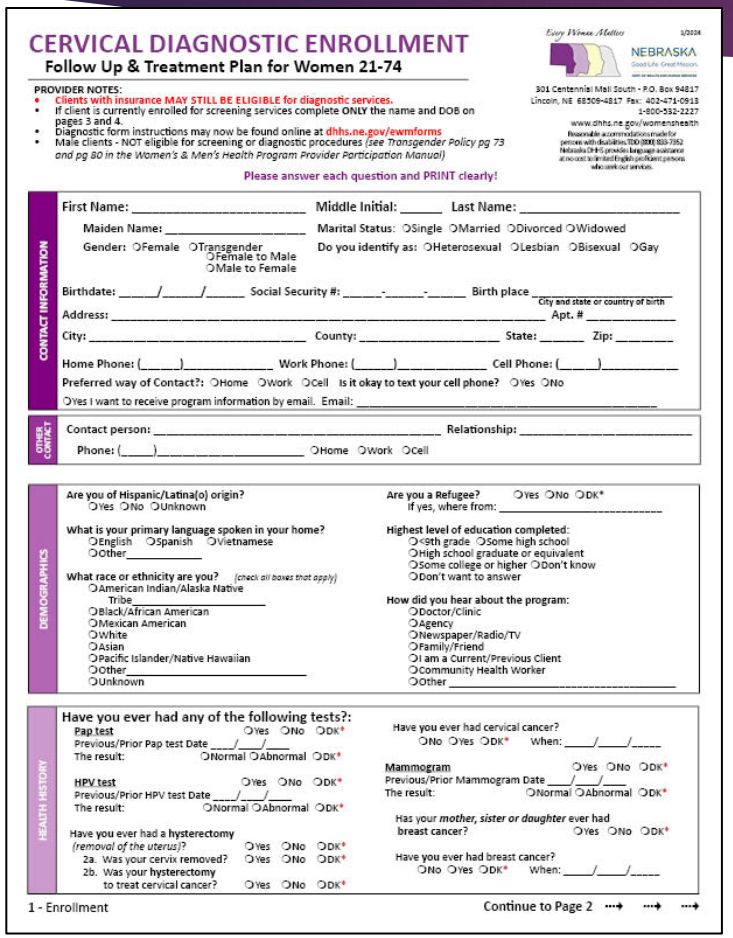


Where to find our forms

- Forms can be downloaded and printed out from here: www.dhhs.ne.gov/ewmforms
- Bookmark this page!
- Cervical Diagnostic forms are available in English and Spanish
- Instructions are no longer printed as part of the form but can be found online



If you have forms in your office…



CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

Every Woman Matters 1/2024

NEBRASKA Good Life. Great Mission.

301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352. Nebraska DHHS provides language assistance at no cost to limited English proficient persons who seek our services.

PROVIDER NOTES:
- Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.
- If client is currently enrolled for screening services complete ONLY the name and DOB on pages 3 and 4.
- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 73 and pg 80 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed
Gender: ○Female ○Transgender ○Female to Male ○Male to Female ○Male to Female
Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay
Birthdate: ____/____/____ Social Security #: ____-____-____ Birth place _____ (City and state or country of birth)
Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____
Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No
○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____
Phone: (____)_____ ○Home ○Work ○Cell

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin? ○Yes ○No ○Unknown
Are you a Refugee? ○Yes ○No ○DK*
If yes, where from: _____
What is your primary language spoken in your home? ○English ○Spanish ○Vietnamese ○Other_____
Highest level of education completed: ○<9th grade ○Some high school ○High school graduate or equivalent ○Some college or higher ○Don't know ○Don't want to answer
What race or ethnicity are you? *(check all boxes that apply)* ○American Indian/Alaska Native Tribe _____ ○Black/African American ○Mexican American ○White ○Asian ○Pacific Islander/Native Hawaiian ○Other_____ ○Unknown
How did you hear about the program: ○Doctor/Clinic ○Agency ○Newspaper/Radio/TV ○Family/Friend ○I am a Current/Previous Client ○Community Health Worker ○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:
Pap test ○Yes ○No ○DK*
Previous/Prior Pap test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*
HPV test ○Yes ○No ○DK*
Previous/Prior HPV test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*
Have you ever had a hysterectomy *(removal of the uterus)*? ○Yes ○No ○DK*
2a. Was your cervix removed? ○Yes ○No ○DK*
2b. Was your hysterectomy to treat cervical cancer? ○Yes ○No ○DK*
Have you ever had cervical cancer? ○No ○Yes ○DK* When: ____/____/____
Mammogram ○Yes ○No ○DK*
Previous/Prior Mammogram Date ____/____/____
The result: ○Normal ○Abnormal ○DK*
Has your *mother, sister or daughter* ever had breast cancer? ○Yes ○No ○DK*
Have you ever had breast cancer? ○No ○Yes ○DK* When: ____/____/____

1 - Enrollment Continue to Page 2 ⇢ ⇢ ⇢

- Please check the date in the top right corner
- We prefer forms dated 2015 or later
- The newer the better - these forms change frequently as our program eligibility evolves
- Always go to the website for most updated version

Enrolling Clients- Part One

CLIENTS THAT ARE NOT CURRENTLY ENROLLED IN EWM

- NEVER BEEN IN EWM BEFORE

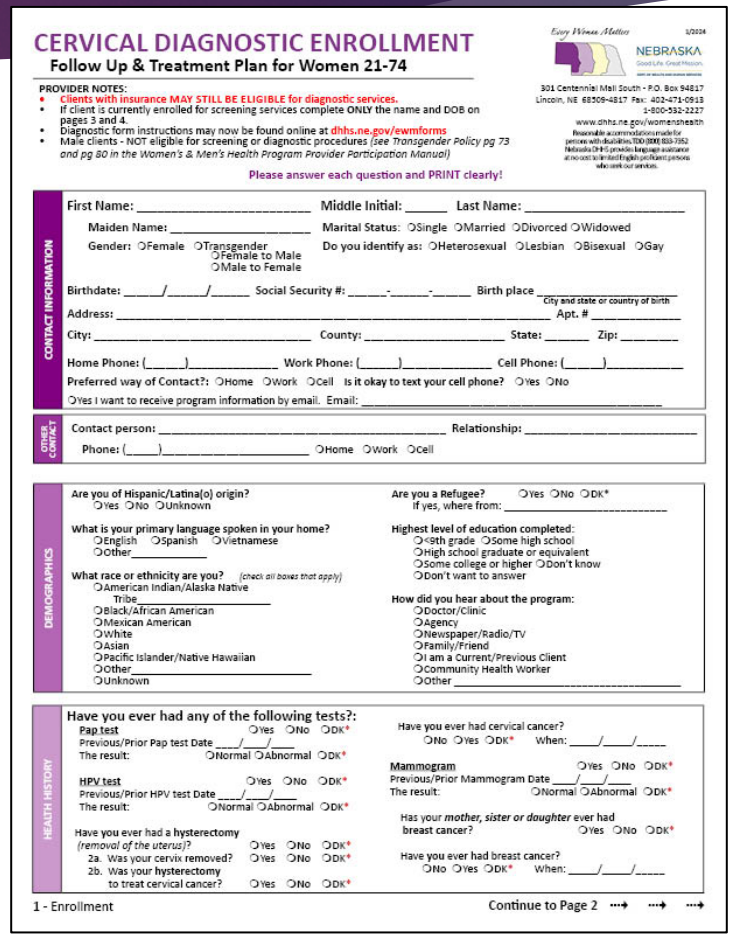
OR

- HAVE BEEN ENROLLED IN EWM OVER ONE YEAR AGO AND NEED UPDATED ENROLLMENT INFORMATION

Enrolling Clients Diagnostically
– Patients not yet enrolled in EWM

- **Your client does not have to be currently enrolled in Every Woman Matters to use the diagnostic form.**

- Clients 21-74 with an abnormal Pap test may be enrolled immediately by using this form as long as they:
  - meet the income guidelines
  - meet citizenship requirements
  - have abnormal screening results within the last 6 months.



CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

Every Woman Matters 1/2024

NEBRASKA

301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
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Nebraska DHHS provides language assistance at no cost to limited English proficient persons who seek our services.

PROVIDER NOTES:
- Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.
- If client is currently enrolled for screening services complete ONLY the name and DOB on pages 3 and 4.
- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 73 and pg 80 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed
Gender: ○Female ○Transgender ○Female to Male ○Male to Female
Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay
Birthdate: ____/____/____ Social Security #: ____-____-____ Birth place _____ City and state or country of birth
Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____
Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No
○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____
Phone: (____)_____ ○Home ○Work ○Cell

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin? ○Yes ○No ○Unknown
What is your primary language spoken in your home? ○English ○Spanish ○Vietnamese ○Other_____
What race or ethnicity are you? *(check all boxes that apply)*
○American Indian/Alaska Native Tribe_____
○Black/African American
○Mexican American
○White
○Asian
○Pacific Islander/Native Hawaiian
○Other_____
○Unknown

Are you a Refugee? ○Yes ○No ○DK*
If yes, where from: _____
Highest level of education completed: ○<6th grade ○Some high school ○High school graduate or equivalent ○Some college or higher ○Don't know ○Don't want to answer
How did you hear about the program: ○Doctor/Clinic ○Agency ○Newspaper/Radio/TV ○Family/Friend ○I am a Current/Previous Client ○Community Health Worker ○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:
Pap test ○Yes ○No ○DK*
Previous/Prior Pap test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*
HPV test ○Yes ○No ○DK*
Previous/Prior HPV test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*
Have you ever had a hysterectomy *(removal of the uterus)*? ○Yes ○No ○DK*
2a. Was your cervix removed? ○Yes ○No ○DK*
2b. Was your hysterectomy to treat cervical cancer? ○Yes ○No ○DK*

Have you ever had cervical cancer? ○No ○Yes ○DK* When: ____/____/____
Mammogram ○Yes ○No ○DK*
Previous/Prior Mammogram Date ____/____/____
The result: ○Normal ○Abnormal ○DK*
Has your *mother, sister or daughter* ever had breast cancer? ○Yes ○No ○DK*
Have you ever had breast cancer? ○No ○Yes ○DK* When: ____/____/____

1 - Enrollment

Continue to Page 2 ⇢ ⇢ ⇢

Enrolling Clients Diagnostically
– Patients not yet enrolled in EWM

Your client does not have to be currently enrolled in Every Woman Matters to use the diagnostic form.

Clients 21-74 with abnormal Pap tests may be enrolled immediately by using this form as long as they:

- meet the income guidelines
- meet citizenship requirements
- have abnormal screening results within the last 6 months.

Income Guidelines

Eligible clients must be within 250% of the Federal Poverty Guidelines.

Current income guidelines can be found at https://dhhs.ne.gov/Documents/EWM_Income_Guidelines.pdf

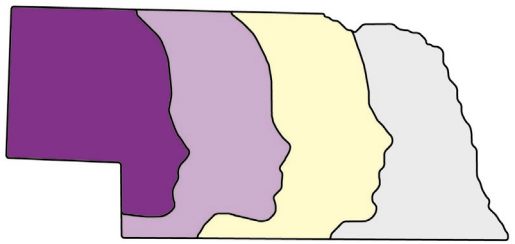
United States Resident

Clients must comply with Neb. Rev. Stat. §§4-108 through §§4-114, being either a US citizen or Qualified Alien under the Federal Immigration and Nationality Act.

- Qualified Aliens ***must*** submit a front ***and*** back copy of their Permanent Resident Card with their application.

Income guidelines

Every Woman Matters



Women's and Men's Health Programs
Income Eligibility Scale
for Every Woman Matters

Effective November 1, 2023-June 30, 2024

Yearly Income

# of People in Household	FREE	$5.00 Donation
1	0-$14,580	$14,581-36,450
2	0-$19,720	$19,721-49,300
3	0-$24,860	$24,861-62,150
4	0-$30,000	$30,001-75,000
5	0-$35,140	$35,141-87,850
6	0-$40,280	$40,281-100,700
7	Call 1-800-532-2227	

Monthly Income

# of People in Household	FREE	$5.00 Donation
1	0-$1,215	$1,216-3,038
2	0-$1,643	$1,644-4,108
3	0-$2,072	$2,073-5,180
4	0-$2,500	$2,501-6,250
5	0-$2,928	$2,929-7,320
6	0-$3,357	$3,358-8,393
7	Call 1-800-532-2227	

Note: *When Screening Cards are sent to clients, they will have an opportunity to make the suggested $5 donation back to the program to help women receive screening services.*

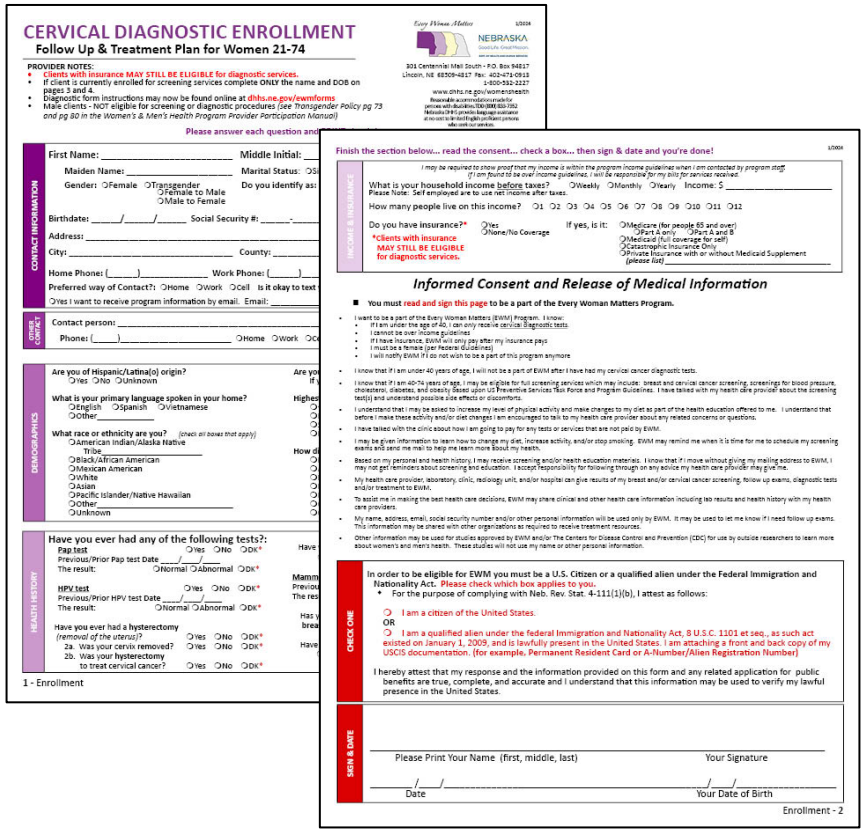
301 Centennial Mall South ~ P.O. Box 94817 ~ Lincoln, NE 68509-4817
Toll Free: 800-532-2227 ~ Local: 402-471-0929 ~ Fax: 402-471-0913
www.dhhs.ne.gov/EWM

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Enrolling Clients Diagnostically

– Patients not yet enrolled in EWM



CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

PROVIDER NOTES:

- Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.
- If client is currently enrolled for screening services complete ONLY the name and DOB on pages 3 and 4.
- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 73 and pg 80 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and

CONTACT INFORMATION

First Name: _____ Middle Initial: ___

Maiden Name: _____ Marital Status: ○Si

Gender: ○Female ○Transgender ○Female to Male ○Male to Female Do you identify as:

Birthdate: ____/____/____ Social Security #: _____-____

Address: _____

City: _____ County: _____

Home Phone: (____)_____ Work Phone: (____)___

Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text

○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____

Phone: (____)_____ ○Home ○Work ○C

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin? ○Yes ○No ○Unknown Are yo If y

What is your primary language spoken in your home? ○English ○Spanish ○Vietnamese ○Other_____ Highes

What race or ethnicity are you? *(check all boxes that apply)* ○American Indian/Alaska Native Tribe_____ ○Black/African American ○Mexican American ○White ○Asian ○Pacific Islander/Native Hawaiian ○Other_____ ○Unknown How d

HEALTH HISTORY

Have you ever had any of the following tests?:

Pap test ○Yes ○No ○DK* Have

Previous/Prior Pap test Date ____/____/____

The result: ○Normal ○Abnormal ○DK*

HPV test ○Yes ○No ○DK* Mamm

Previous/Prior HPV test Date ____/____/____ Previou

The result: ○Normal ○Abnormal ○DK* The res

Have you ever had a hysterectomy *(removal of the uterus)*? ○Yes ○No ○DK* Has y

2a. Was your cervix removed? ○Yes ○No ○DK* brea

2b. Was your hysterectomy to treat cervical cancer? ○Yes ○No ○DK* Have

1 - Enrollment

Finish the section below... read the consent... check a box... then sign & date and you're done!

INCOME & INSURANCE

I may be required to show proof that my income is within the program income guideline when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.

What is your household income before taxes? ○Weekly ○Monthly ○Yearly Income: $ _____

Please Note: Self employed are to use net income after taxes.

How many people live on this income? ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ○11 ○12

Do you have insurance?* ○Yes ○None/No Coverage

*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

If yes, is it: ○Medicare (for people 65 and over) ○Part A only ○Part A and B ○Medicaid (full coverage for self) ○Catastrophic Insurance Only ○Private Insurance with or without Medicaid Supplement *(please list)* _____

Informed Consent and Release of Medical Information

■ **You must read and sign this page to be a part of the Every Woman Matters Program.**

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
  - If I am under the age of 40, I can only receive cervical diagnostic tests
  - I cannot be over income guidelines
  - If I have insurance, EWM will only pay after my insurance pays
  - I must be a female (per Federal Guidelines)
  - I will notify EWM if I do not wish to be a part of this program anymore
- I know that if I am under 40 years of age, I will not be a part of EWM after I have had my cervical cancer diagnostic tests.
- I know that if I am 40-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and Program Guidelines. I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM.
- I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
- My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and/or cervical cancer screening, follow up exams, diagnostic tests and/or treatment to EWM.
- To assist me in making the best health care decisions, EWM may share clinical and other health care information including lab results and health history with my health care providers.
- My name, address, email, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

CHECK ONE

In order to be eligible for EWM you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. Please check which box applies to you.

- For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows:

○ I am a citizen of the United States.

OR

○ I am a qualified alien under the federal Immigration and Nationality Act, 8 U.S.C. 1101 et seq., as such act existed on January 1, 2009, and is lawfully present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, Permanent Resident Card or A-Number/Alien Registration Number)

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

SIGN & DATE

_____ Please Print Your Name (first, middle, last) Your Signature

____/____/____ Date ____/____/____ Your Date of Birth

Enrollment - 2

Patients who have not yet enrolled in the program must complete pages 1-2 of the CDIA with:

- contact information
- demographics
- breast and cervical history
- income and insurance
- citizenship status
- signature (date of signature should be the date of first diagnostic service in order for it to be reimbursed)

Enrolling Clients – Part Two

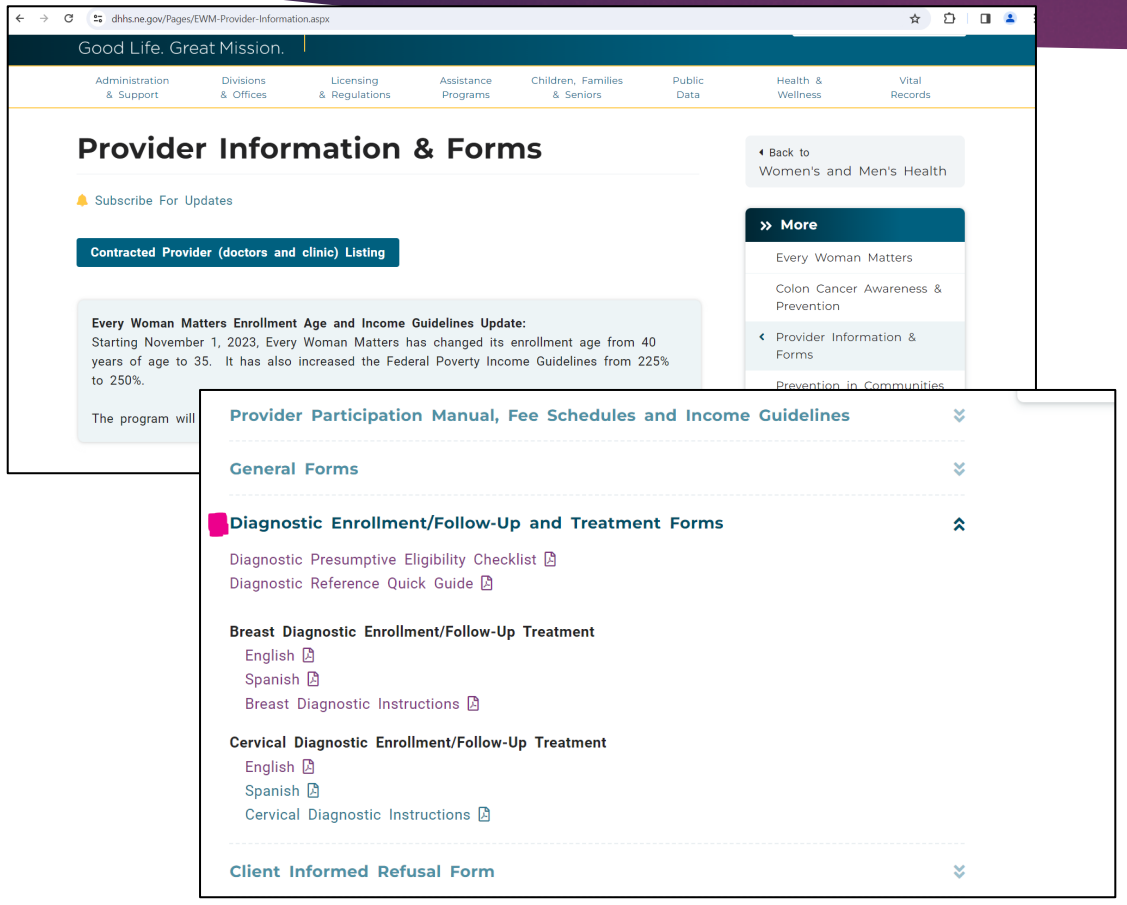
CLIENTS THAT **ARE** CURRENTLY ENROLLED IN EWM OR STATE PAP PLUS PROGRAM

Enrolling Clients Diagnostically
– Patients **already enrolled** in EWM

If your client meets the following criteria, pages 1-2 of the cervical diagnostic form (CDIA) **do not** need to be completed or returned:

- Age 35-74 and has recently completed a Healthy Lifestyle Questionnaire and had a EWM well woman screening visit
- Age 21-74 and is currently enrolled in the State Pap Plus Program

NEW! Quick reference guides online!



- **When in doubt, check these out!**
- Go to www.dhhs.ne.gov/ewmforms
- There is a Checklist and a Reference Guide for eligibility for diagnostic services so you don't need to have all of this memorized
  - Diagnostic Presumptive Eligibility Checklist
  - Diagnostic Reference Quick Guide
- Print them off for your clinic

NEW - Quick reference guides

Diagnostic Presumptive Eligibility Checklist

1. **Women ages 18 and up for breast cancer diagnostics after abnormal screening results that occured within the last 6 months.**

2. **Women ages 21 and up for cervical cancer diagnostics after abnormal screening results that occured within the last 6 months.**

3. **Clients ages 25-39 with documented personal history of BRCA1 of BRCA2 would be eligible for annual breast MRI screening.**

4. **Breast or Cervical Cancer Diagnostic Form completed in its entirety**
   - Incomplete forms will be returned to the provider office

5. **Income falls within Income Eligibility Scale**
   - Income eligibility scale is found on the Every Woman Matters website: http://dhhs.ne.gov/EWMforms

6. **Insurance coverage noted on form**
   - Patient may have private insurance and be responsible for co-pays and deductibles
   - Patient cannot have Medicare part B or Medicaid

7. **Patient is a U.S. citizen or qualified alien under the Federal Nationality Act**
   - Patient has marked the box attesting that they are as US citizen or qualified alien
   - Copy of front and back of USCIS documentation provided with program form (Permanent Resident Card)

8. **Medical Release Form is signed and dated by patient (this also includes listing client date of birth and printing client name).**

9. **Services provided follow program guidelines**
   - Guidelines are printed on Diagnostic Forms
   - Program adheres to the current ASCCP Consensus Guidelines for Cervical Abnormalities
   - Program adheres to the NCCN Screening and Diagnostic Guidelines for Breast abnormalities

10. **The initial visit may be reimbursed by EWM if the provider determines that CBE is suspicious for breast malignancy and additional tests are required to reach a final diagnosis.**

Instructions for the Breast and Cerivical Diagnostic Enrollment Forms can be found on the Every Woman Matters website:
http://dhhs.ne.gov/EWMForms

2023

REFERENCE GUIDE FOR PROVIDERS

Qualifying Criteria Quick Guide

DIAGNOSTIC SERVICES

Gender	Females Only
Age	18-74 for Breast Diagnostic Services 21-74 for Cervical Diagnostic Services
Income	Must meet Income Guidelines
Health Insurance	CLIENTS MAY HAVE INSURANCE
Citizenship	Must be a US Citizen or Permanent Resident* **must provide front and back copy of Permanent Resident card*
Health Status:	Must need services to diagnose breast or cervical cancer
Forms	https://dhhs.ne.gov/EWMForms Only forms printed 2022 or later are accepted (*Date found in upper right-hand corner*)
Enrollment	BREAST can be enrolled as a diagnostic client at the provider's office for diagnostic work up for breast issues or if they have had an abnormal screening mammogram. • Breast enrollments must follow the National Comprehensive Cancer Network (NCCN) guidelines. If a client has a suspicious clinical breast exam, a diagnostic mammogram alone does not meet clinical standards (shown on the Breast Diagnostic Enrollment Follow Up and Treatment Plan Form (BDIA)). CERVICAL can be enrolled as a diagnostic client at the provider's office for diagnostic work up for abnormal pap tests. • Cervical enrollments must follow the current ASCCP Guidelines (shown on the Cervical Diagnostic Enrollment Follow Up and Treatment Plan Form (CDIA)).

Women's and Men's Health Programs
Income Eligibility Scale
for Every Woman Matters
Effective July 1, 2023-June 30, 2024

Yearly Income

# of People in Household	FREE	$5.00 Donation
1	0-$14,580	$14,581-32,805
2	0-$19,720	$19,721-44,370
3	0-$24,860	$24,861-55,935
4	0-$30,000	$30,001-67,500
5	0-$35,140	$35,141-79,065
6	0-$40,280	$40,281-90,630
7	Call 1-800-532-2227	

Monthly Income

# of People in Household	FREE	$5.00 Donation
1	0-$1,215	$1,216-2,734
2	0-$1,643	$1,644-3,697
3	0-$2,072	$2,073-4,662
4	0-$2,500	$2,501-5,625
5	0-$2,928	$2,929-6,588
6	0-$3,357	$3,358-7,553
7	Call 1-800-532-2227	

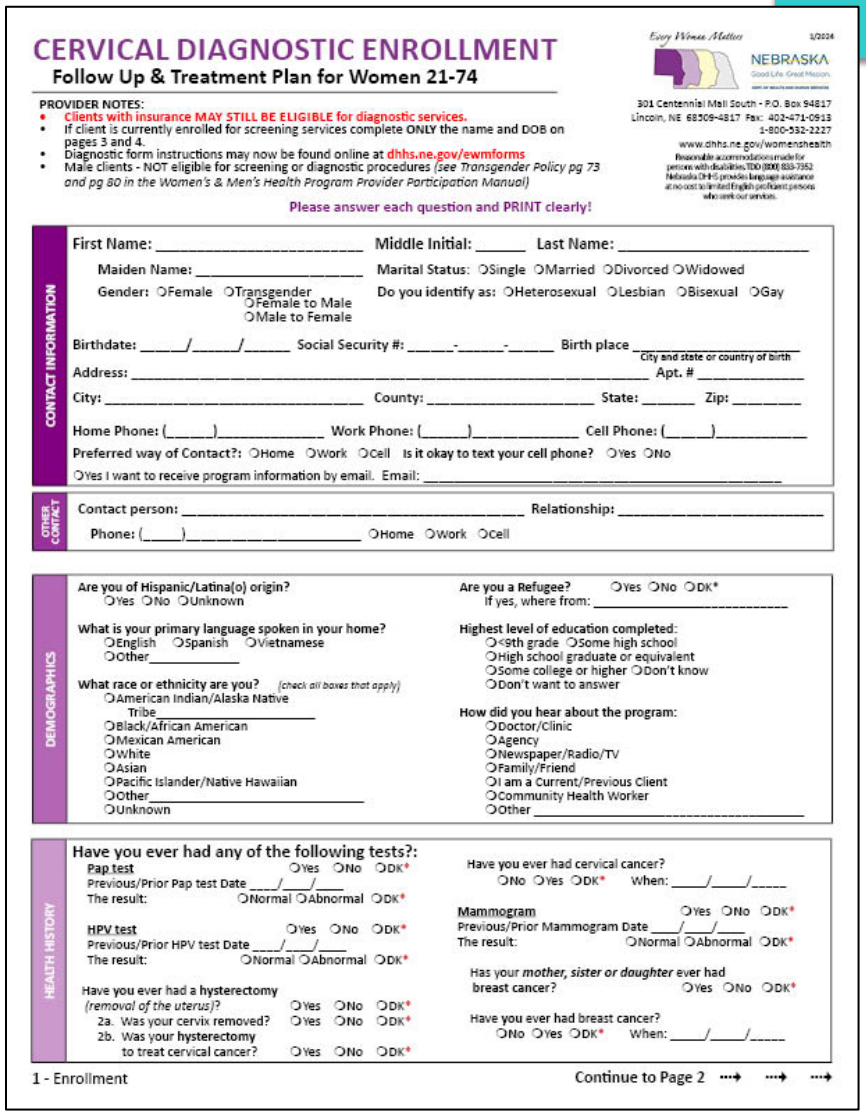
Note: When Screening Cards are sent to clients, they will have an opportunity to make the suggested $5 donation back to the program to help women receive screening services.

Please call 800-532-2227 to speak with a program Nurse regarding completion of diagnostic forms or to answer diagnostic questions.

Every Woman Matters

PO. Box 94817
Lincoln, NE 68509
Toll Free: 800-532-2227
Fax: 402-471-0913
dhhs.ewm@nebraska.gov

Completing Cervical Diagnostic Enrollment Forms



CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

Every Woman Matters 1/2024

NEBRASKA
Good Life. Great Mission.

301 Centennial Mall South • P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352
Nebraska DHHS provides language assistance at no cost to limited English proficient persons who seek our services.

PROVIDER NOTES:

- **Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.**
- If client is currently enrolled for screening services complete **ONLY** the name and DOB on pages 3 and 4.
- Diagnostic form instructions may now be found online at **dhhs.ne.gov/ewmforms**
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 73 and pg 80 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed

Gender: ○Female ○Transgender ○Female to Male ○Male to Female

Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay

Birthdate: ____/____/____ Social Security #: ____-____-____ Birth place _____ (City and state or country of birth)

Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No

○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____

Phone: (____)_____ ○Home ○Work ○Cell

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin?
○Yes ○No ○Unknown

What is your primary language spoken in your home?
○English ○Spanish ○Vietnamese
○Other_____

What race or ethnicity are you? *(check all boxes that apply)*
○American Indian/Alaska Native
Tribe_____
○Black/African American
○Mexican American
○White
○Asian
○Pacific Islander/Native Hawaiian
○Other_____
○Unknown

Are you a Refugee? ○Yes ○No ○DK*
If yes, where from: _____

Highest level of education completed:
○<9th grade ○Some high school
○High school graduate or equivalent
○Some college or higher ○Don't know
○Don't want to answer

How did you hear about the program:
○Doctor/Clinic
○Agency
○Newspaper/Radio/TV
○Family/Friend
○I am a Current/Previous Client
○Community Health Worker
○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:

Pap test ○Yes ○No ○DK*
Previous/Prior Pap test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

HPV test ○Yes ○No ○DK*
Previous/Prior HPV test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

Have you ever had a hysterectomy *(removal of the uterus)*? ○Yes ○No ○DK*
2a. Was your cervix removed? ○Yes ○No ○DK*
2b. Was your hysterectomy to treat cervical cancer? ○Yes ○No ○DK*

Have you ever had cervical cancer?
○No ○Yes ○DK* When: ____/____/____

Mammogram ○Yes ○No ○DK*
Previous/Prior Mammogram Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

Has your *mother, sister or daughter* ever had breast cancer? ○Yes ○No ○DK*

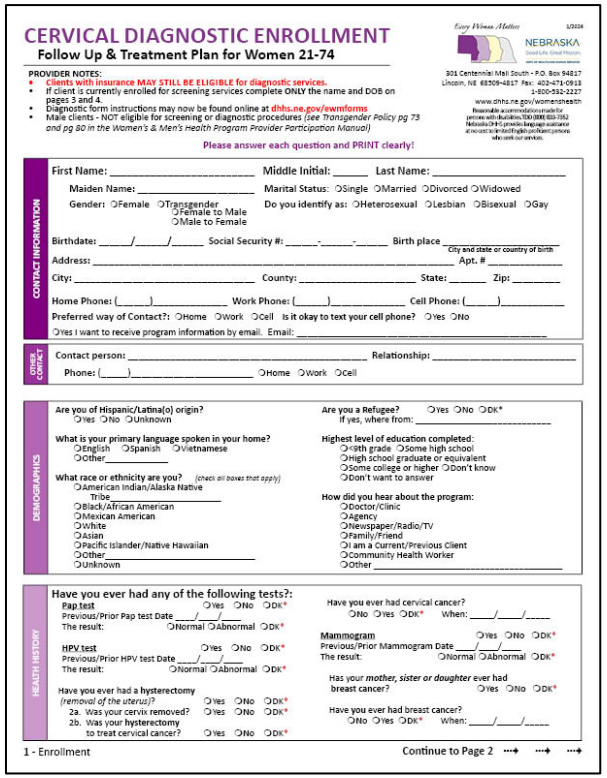
Have you ever had breast cancer?
○No ○Yes ○DK* When: ____/____/____

1 - Enrollment

Continue to Page 2 ⇢ ⇢ ⇢

First, check to make sure client filled everything out on pages 1 and 2

(for clients not already enrolled in EWM)



CERVICAL DIAGNOSTIC ENROLLMENT

Follow Up & Treatment Plan for Women 21-74

PROVIDER NOTES:

- Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.
- If client is currently enrolled for screening services complete ONLY the name and DOB on pages 3 and 4.
- Diagnostic form instructions may now be found online at dhhs.ne.gov/ewmforms
- Male clients - NOT eligible for screening or diagnostic procedures *(see Transgender Policy pg 73 and pg 80 in the Women's & Men's Health Program Provider Participation Manual)*

Please answer each question and PRINT clearly!

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Maiden Name: _____ Marital Status: ○Single ○Married ○Divorced ○Widowed

Gender: ○Female ○Transgender ○Female to Male ○Male to Female Do you identify as: ○Heterosexual ○Lesbian ○Bisexual ○Gay

Birthdate: _____/_____/_____ Social Security #: _____-_____-_____ Birth place _____ City and state or country of birth

Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Preferred way of Contact?: ○Home ○Work ○Cell Is it okay to text your cell phone? ○Yes ○No

○Yes I want to receive program information by email. Email: _____

OTHER CONTACT

Contact person: _____ Relationship: _____

Phone: (_____)_____ ○Home ○Work ○Cell

DEMOGRAPHICS

Are you of Hispanic/Latina(o) origin? ○Yes ○No ○Unknown

Are you a Refugee? ○Yes ○No ○DK* If yes, where from: _____

What is your primary language spoken in your home? ○English ○Spanish ○Vietnamese ○Other_____

Highest level of education completed: ○<6th grade ○Some high school ○High school graduate or equivalent ○Some college or higher ○Don't know ○Don't want to answer

What race or ethnicity are you? *(check all boxes that apply)* ○American Indian/Alaska Native Tribe_____ ○Black/African American ○Mexican American ○White ○Asian ○Pacific Islander/Native Hawaiian ○Other _____ ○Unknown

How did you hear about the program: ○Doctor/Clinic ○Agency ○Newspaper/Radio/TV ○Family/Friend ○I am a Current/Previous Client ○Community Health Worker ○Other _____

HEALTH HISTORY

Have you ever had any of the following tests?:

Pap test ○Yes ○No ○DK*
Previous/Prior Pap test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

HPV test ○Yes ○No ○DK*
Previous/Prior HPV test Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

Have you ever had a hysterectomy *(removal of the uterus)*? ○Yes ○No ○DK*
2a. Was your cervix removed? ○Yes ○No ○DK*
2b. Was your hysterectomy to treat cervical cancer? ○Yes ○No ○DK*

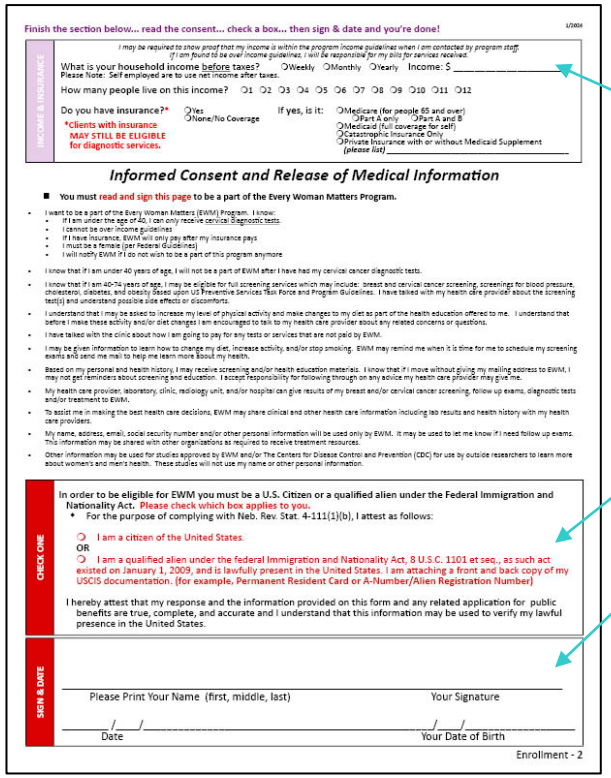
Have you ever had cervical cancer? ○No ○Yes ○DK* When: ____/____/_____

Mammogram ○Yes ○No ○DK*
Previous/Prior Mammogram Date ____/____/____
The result: ○Normal ○Abnormal ○DK*

Has your *mother, sister or daughter* ever had breast cancer? ○Yes ○No ○DK*

Have you ever had breast cancer? ○No ○Yes ○DK* When: ____/____/_____

1 - Enrollment Continue to Page 2 ⇢ ⇢ ⇢



Finish the section below... read the consent... check a box... then sign & date and you're done!

INCOME & INSURANCE

I may be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.

What is your household income before taxes? ○Weekly ○Monthly ○Yearly Income: $ _____

How many people live on this income? ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ○11 ○12

Do you have insurance?* ○Yes ○None/No Coverage If yes, is it: ○Medicare (for people 65 and over) ○Part A only ○Part A and B ○Medicaid (full coverage for self) ○Catastrophic Insurance Only ○Private Insurance with or without Medicaid Supplement *(please list)* _____

*clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

Informed Consent and Release of Medical Information

■ **You must read and sign this page to be a part of the Every Woman Matters Program.**

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
  - If I am under the age of 40, I can only receive cervical diagnostic tests.
  - I cannot be over income guidelines.
  - If I have insurance, EWM will only pay after my insurance pays.
  - I must be a female (per Federal Guidelines).
  - I will notify EWM if I do not wish to be a part of this program anymore.
- I know that if I am under 40 years of age, I will not be a part of EWM after I have had my cervical cancer diagnostic tests.
- I know that if I am 40-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and Program Guidelines. I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM.
- I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
- My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and/or cervical cancer screening, follow up exams, diagnostic tests and/or treatment to EWM.
- To assist me in making the best health care decisions, EWM may share clinical and other health care information including lab results and health history with my health care providers.
- My name, address, email, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

CHECK ONE

In order to be eligible for EWM you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. **Please check which box applies to you.**

- For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows:

❍ I am a citizen of the United States.

OR

❍ I am a qualified alien under the federal Immigration and Nationality Act, 8 U.S.C. 1101 et seq., as such act existed on January 1, 2009, and is lawfully present in the United States. I am attaching a front and back copy of my USCIS documentation. **(for example, Permanent Resident Card or A-Number/Alien Registration Number)**

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

SIGN & DATE

_____ _____

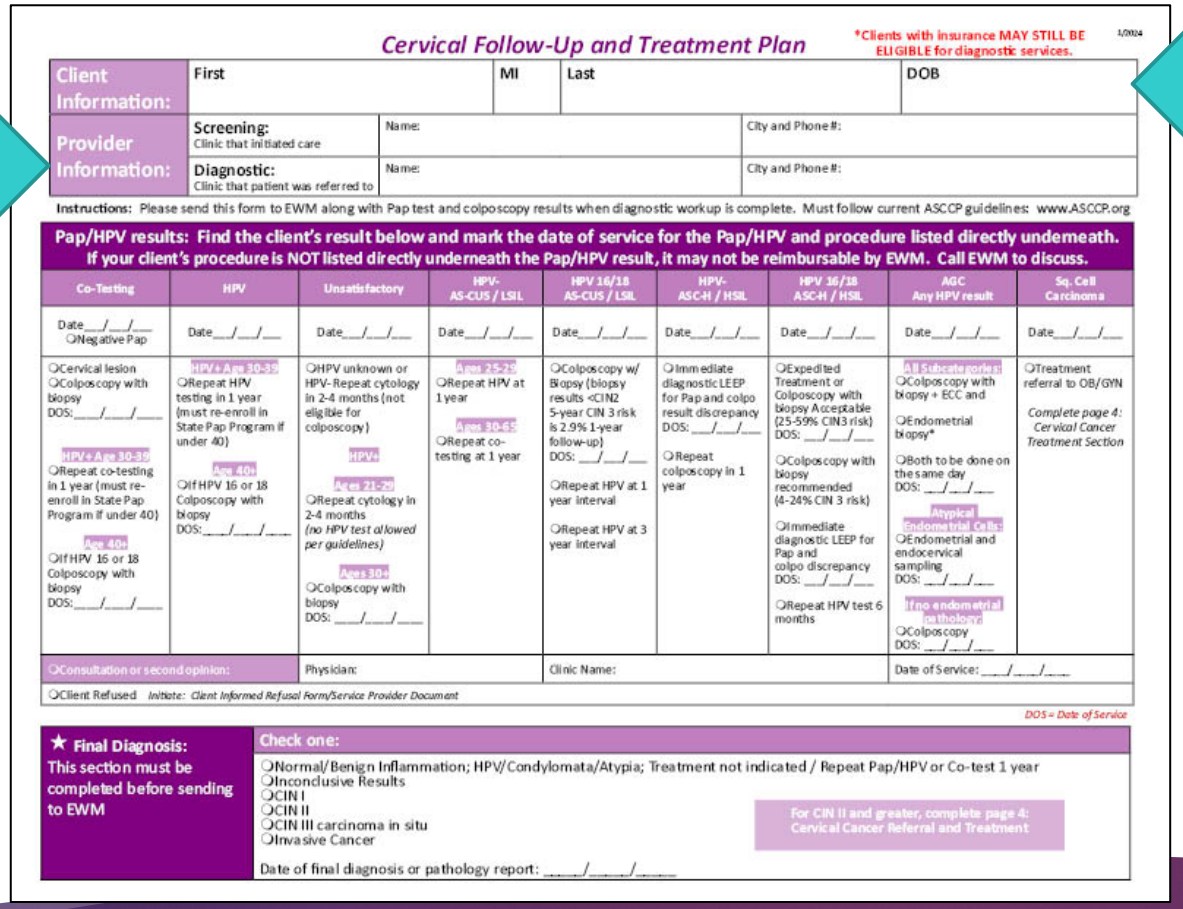
Please Print Your Name (first, middle, last) Your Signature

_____/_____/_____ _____/_____/_____

Date Your Date of Birth

Enrollment - 2

- EWM will return the form to you if sections are left blank
- Income, attestation, and signature are all required
- Spanish forms available online



Cervical Follow-Up and Treatment Plan

*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

1/2024

Client Information:	First	MI	Last	DOB
Provider Information:	**Screening:** Clinic that initiated care	Name:	City and Phone #:	
	Diagnostic: Clinic that patient was referred to	Name:	City and Phone #:	

Instructions: Please send this form to EWM along with Pap test and colposcopy results when diagnostic workup is complete. Must follow current ASCCP guidelines: www.ASCCP.org

Pap/HPV results: Find the client's result below and mark the date of service for the Pap/HPV and procedure listed directly underneath. If your client's procedure is NOT listed directly underneath the Pap/HPV result, it may not be reimbursable by EWM. Call EWM to discuss.

Co-Testing	HPV	Unsatisfactory	HPV-AS-CUS / LSIL	HPV 16/18 AS-CUS / LSIL	HPV-ASC-H / HSIL	HPV 16/18 ASC-H / HSIL	AGC Any HPV result	Sq. Cell Carcinoma
Date___/___/___ ❍Negative Pap	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___
❍Cervical lesion ❍Colposcopy with biopsy DOS:___/___/___ HPV+ Age 30-35 ❍Repeat co-testing in 1 year (must re-enroll in State Pap Program if under 40) Age 40+ ❍If HPV 16 or 18 Colposcopy with biopsy DOS:___/___/___	HPV+ Age 30-35 ❍Repeat HPV testing in 1 year (must re-enroll in State Pap Program if under 40) Age 40+ ❍If HPV 16 or 18 Colposcopy with biopsy DOS:___/___/___	❍HPV unknown or HPV- Repeat cytology in 2-4 months (not eligible for colposcopy) HPV+ Ages 21-29 ❍Repeat cytology in 2-4 months *(no HPV test allowed per guidelines)* Ages 30+ ❍Colposcopy with biopsy DOS: ___/___/___	Ages 21-29 ❍Repeat HPV at 1 year Ages 30-65 ❍Repeat co-testing at 1 year	❍Colposcopy w/ Biopsy (biopsy results <CIN2 5-year CIN 3 risk is 2.9% 1-year follow-up) DOS: ___/___/___ ❍Repeat HPV at 1 year interval ❍Repeat HPV at 3 year interval	❍Immediate diagnostic LEEP for Pap and colpo result discrepancy DOS: ___/___/___ ❍Repeat colposcopy in 1 year	❍Expedited Treatment or Colposcopy with biopsy Acceptable (25-59% CIN3 risk) DOS: ___/___/___ ❍Colposcopy with biopsy recommended (4-24% CIN 3 risk) ❍Immediate diagnostic LEEP for Pap and colpo discrepancy DOS: ___/___/___ ❍Repeat HPV test 6 months	All Subcategories ❍Colposcopy with biopsy + ECC and ❍Endometrial biopsy* ❍Both to be done on the same day DOS: ___/___/___ Atypical Endometrial Cells: ❍Endometrial and endocervical sampling DOS: ___/___/___ If no endometrial pathology ❍Colposcopy DOS: ___/___/___	❍Treatment referral to OB/GYN *Complete page 4: Cervical Cancer Treatment Section*
❍Consultation or second opinion:	Physician:		Clinic Name:				Date of Service: ___/___/___	
❍Client Refused *Initiate: Client Informed Refusal Form/Service Provider Document*								

DOS = Date of Service

★ Final Diagnosis: This section must be completed before sending to EWM	Check one:
	❍Normal/Benign Inflammation; HPV/Condylomata/Atypia; Treatment not indicated / Repeat Pap/HPV or Co-test 1 year ❍Inconclusive Results ❍CIN I ❍CIN II ❍CIN III carcinoma in situ ❍Invasive Cancer For CIN II and greater, complete page 4: Cervical Cancer Referral and Treatment Date of final diagnosis or pathology report: ___/___/___

Complete with the client's name, DOB, and screening provider where her Pap was performed (if applicable)

Fill in your clinic's information under diagnostic provider.

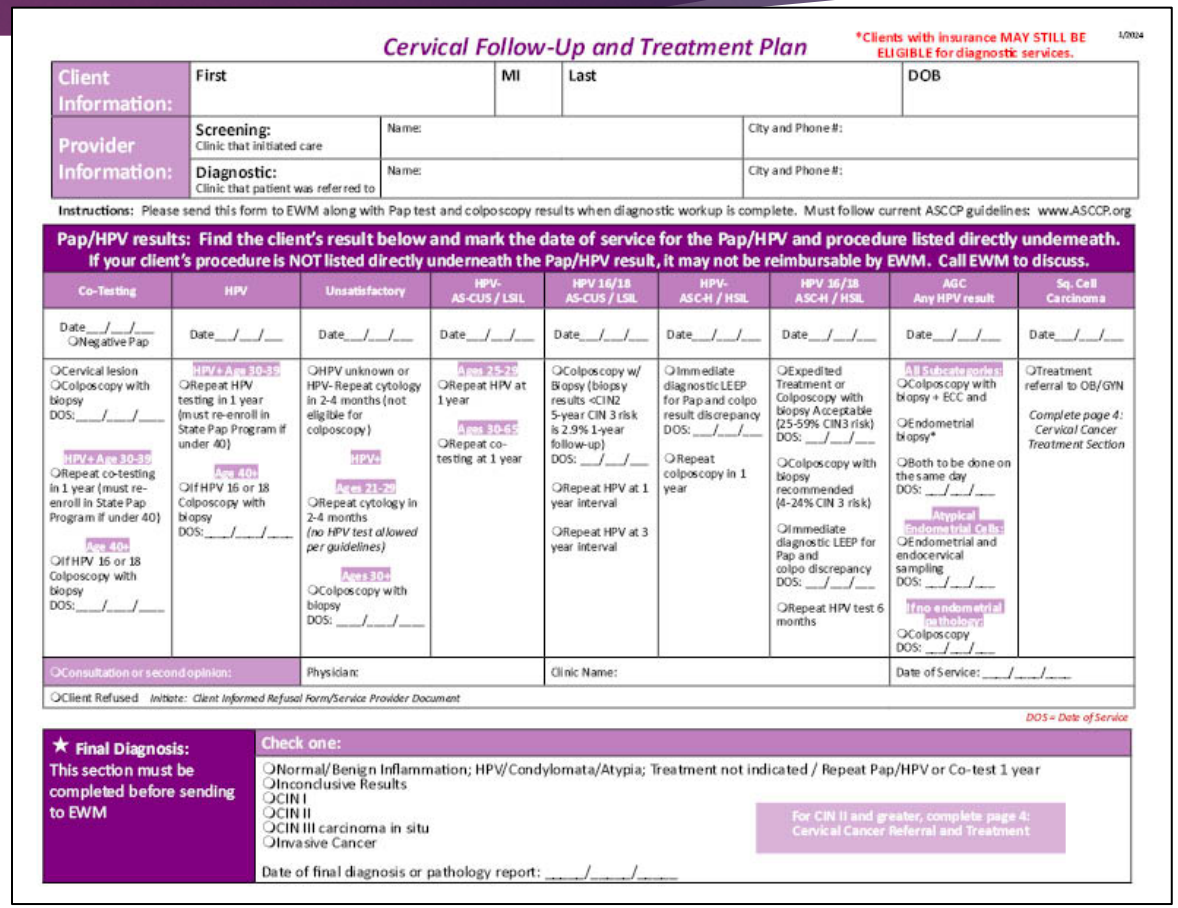
Let's get started!

Page 3 of the Cervical Follow-up & Treatment Plan can be filled out by any member of the health care team at a primary care, OB/GYN or surgical provider's office.

Page 3 – Pap results

Find the client's Pap test result and mark the date of service for the Pap

- Co-Testing with Negative Pap but with visible cervical lesion or HPV+ (for clients age 30+)
- HPV Result
- Unsatisfactory Pap
- Atypical Squamous Cells of Undetermined Significance (ASC-US)
- Low grade Squamous Intraepithelial Lesion (LSIL)
- Atypical Squamous Cells Cannot Rule out High grade (ASC-H)
- High grade Squamous Intraepithelial Lesion (HSIL)
- Atypical Glandular Cells (AGC)
- Squamous Cell Carcinoma



Cervical Follow-Up and Treatment Plan

*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

1/2024

Client Information:	First	MI	Last	DOB
Provider Information:	Screening: Clinic that initiated care	Name:	City and Phone #:	
	Diagnostic: Clinic that patient was referred to	Name:	City and Phone #:	

Instructions: Please send this form to EWM along with Pap test and colposcopy results when diagnostic workup is complete. Must follow current ASCCP guidelines: www.ASCCP.org

Pap/HPV results: Find the client's result below and mark the date of service for the Pap/HPV and procedure listed directly underneath. If your client's procedure is NOT listed directly underneath the Pap/HPV result, it may not be reimbursable by EWM. Call EWM to discuss.

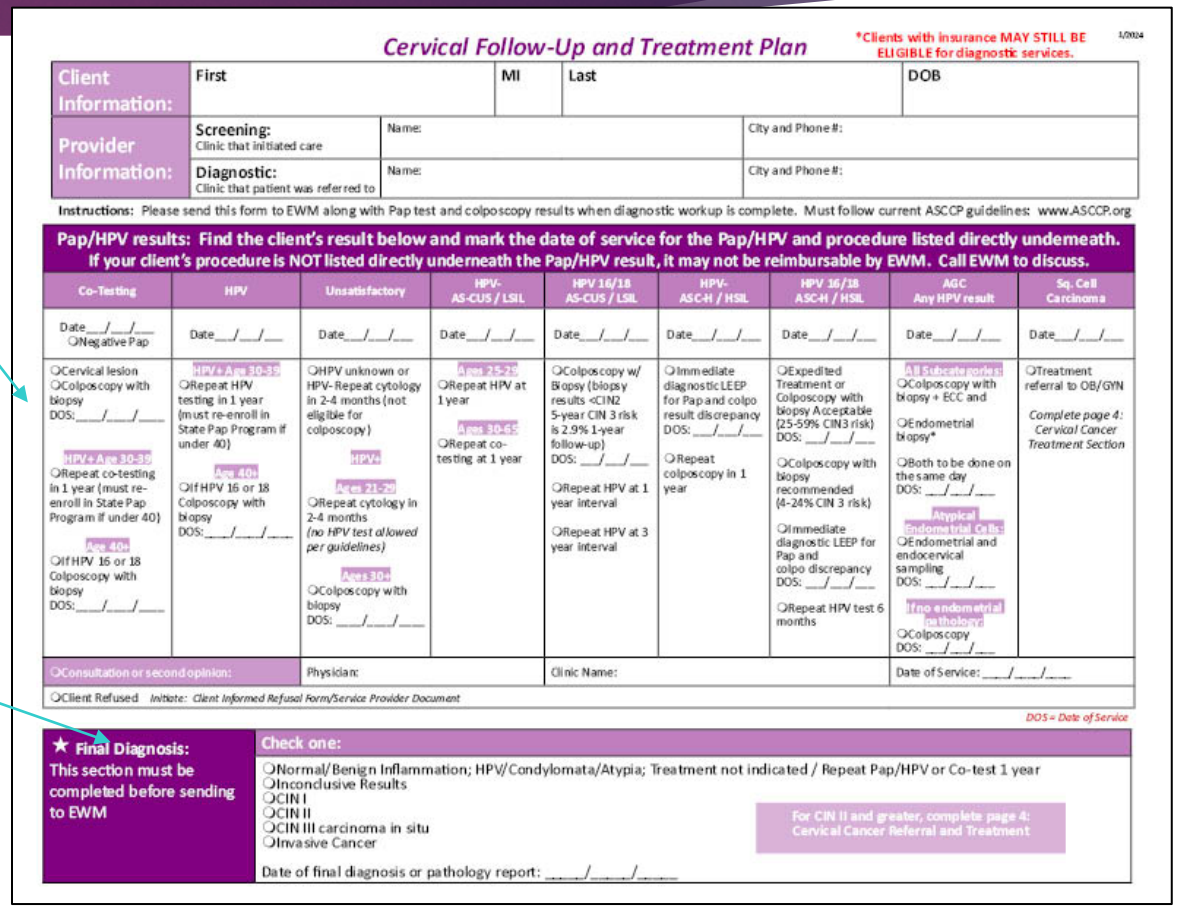
Co-Testing	HPV	Unsatisfactory	HPV- AS-CUS / LSIL	HPV 16/18 AS-CUS / LSIL	HPV- ASC-H / HSIL	HPV 16/18 ASC-H / HSIL	AGC Any HPV result	Sq. Cell Carcinoma
Date___/___/___ ❍Negative Pap	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___
❍Cervical lesion ❍Colposcopy with biopsy DOS:___/___/___ HPV+ Age 30-39 ❍Repeat co-testing in 1 year (must re-enroll in State Pap Program if under 40) Age 40+ ❍If HPV 16 or 18 Colposcopy with biopsy DOS:___/___/___	HPV+ Age 30-39 ❍Repeat HPV testing in 1 year (must re-enroll in State Pap Program if under 40) Age 40+ ❍If HPV 16 or 18 Colposcopy with biopsy DOS:___/___/___	❍HPV unknown or HPV- Repeat cytology in 2-4 months (not eligible for colposcopy) HPV+ Ages 21-29 ❍Repeat cytology in 2-4 months *(no HPV test allowed per guidelines)* Ages 30+ ❍Colposcopy with biopsy DOS:___/___/___	Ages 25-29 ❍Repeat HPV at 1 year Ages 30-65 ❍Repeat co-testing at 1 year	❍Colposcopy w/ Biopsy (biopsy results <CIN2 5-year CIN 3 risk is 2.9% 1-year follow-up) DOS:___/___/___ ❍Repeat HPV at 1 year interval ❍Repeat HPV at 3 year interval	❍Immediate diagnostic LEEP for Pap and colpo result discrepancy DOS:___/___/___ ❍Repeat colposcopy in 1 year	❍Expedited Treatment or Colposcopy with biopsy Acceptable (25-59% CIN3 risk) DOS:___/___/___ ❍Colposcopy with biopsy recommended (4-24% CIN 3 risk) ❍Immediate diagnostic LEEP for Pap and colpo discrepancy DOS:___/___/___ ❍Repeat HPV test 6 months	All Subcategories: ❍Colposcopy with biopsy + ECC and ❍Endometrial biopsy* ❍Both to be done on the same day DOS:___/___/___ Atypical Endometrial Cells: ❍Endometrial and endocervical sampling DOS:___/___/___ If no endometrial pathology: ❍Colposcopy DOS:___/___/___	❍Treatment referral to OB/GYN *Complete page 4: Cervical Cancer Treatment Section*
❍Consultation or second opinion:	Physician:		Clinic Name:				Date of Service:___/___/___	
❍Client Refused *Initiate: Client Informed Refusal Form/Service Provider Document*								

DOS = Date of Service

★ Final Diagnosis: This section must be completed before sending to EWM	Check one:
	❍Normal/Benign Inflammation; HPV/Condylomata/Atypia; Treatment not indicated / Repeat Pap/HPV or Co-test 1 year ❍Inconclusive Results ❍CIN I ❍CIN II ❍CIN III carcinoma in situ ❍Invasive Cancer For CIN II and greater, complete page 4: Cervical Cancer Referral and Treatment Date of final diagnosis or pathology report: ____/____/____

Page 3 –Diagnostic workup and Final Diagnosis

- The row under Pap results shows what procedures are allowable based on age and HPV status for women with those particular Pap test findings. Check the box with the diagnostic procedure done and fill in the date of service.
  - Send corresponding clinical documentation including Pap results or form may be returned to you.
  - If you are a screening provider, form must be given to diagnostic provider for completion before sending to EWM.
  - All clinical documentation including the enrollment is due within 2 weeks of service.
- Check the **final diagnosis and date of diagnosis.**
  - If you do not check a final diagnosis, your form may be returned to you.



Cervical Follow-Up and Treatment Plan

*Clients with insurance MAY STILL BE ELIGIBLE for diagnostic services.

1/2024

Client Information:	First	MI	Last	DOB
Provider Information:	**Screening:** Clinic that initiated care	Name:	City and Phone #:	
	Diagnostic: Clinic that patient was referred to	Name:	City and Phone #:	

Instructions: Please send this form to EWM along with Pap test and colposcopy results when diagnostic workup is complete. Must follow current ASCCP guidelines: www.ASCCP.org

Pap/HPV results: Find the client's result below and mark the date of service for the Pap/HPV and procedure listed directly underneath. If your client's procedure is NOT listed directly underneath the Pap/HPV result, it may not be reimbursable by EWM. Call EWM to discuss.

Co-Testing	HPV	Unsatisfactory	HPV-AS-CUS / LSIL	HPV 16/18 AS-CUS / LSIL	HPV-ASC-H / HSIL	HPV 16/18 ASC-H / HSIL	AGC Any HPV result	Sq. Cell Carcinoma
Date___/___/___ ❍Negative Pap	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___	Date___/___/___
❍Cervical lesion ❍Colposcopy with biopsy DOS:___/___/___ HPV+ Age 30-39 ❍Repeat co-testing in 1 year (must re-enroll in State Pap Program if under 40) Age 40+ ❍If HPV 16 or 18 Colposcopy with biopsy DOS:___/___/___	HPV+ Age 30-39 ❍Repeat HPV testing in 1 year (must re-enroll in State Pap Program if under 40) Age 40+ ❍If HPV 16 or 18 Colposcopy with biopsy DOS:___/___/___	❍HPV unknown or HPV- Repeat cytology in 2-4 months (not eligible for colposcopy) HPV+ Ages 21-29 ❍Repeat cytology in 2-4 months *(no HPV test allowed per guidelines)* Ages 30+ ❍Colposcopy with biopsy DOS: ___/___/___	Ages 25-29 ❍Repeat HPV at 1 year Ages 30-65 ❍Repeat co-testing at 1 year	❍Colposcopy w/ Biopsy (biopsy results <CIN2 5-year CIN 3 risk is 2.9% 1-year follow-up) DOS: ___/___/___ ❍Repeat HPV at 1 year interval ❍Repeat HPV at 3 year interval	❍Immediate diagnostic LEEP for Pap and colpo result discrepancy DOS: ___/___/___ ❍Repeat colposcopy in 1 year	❍Expedited Treatment or Colposcopy with biopsy Acceptable (25-59% CIN3 risk) DOS: ___/___/___ ❍Colposcopy with biopsy recommended (4-24% CIN 3 risk) ❍Immediate diagnostic LEEP for Pap and colpo discrepancy DOS: ___/___/___ ❍Repeat HPV test 6 months	All Subcategories: ❍Colposcopy with biopsy + ECC and ❍Endometrial biopsy* ❍Both to be done on the same day DOS: ___/___/___ Atypical Endometrial Cells: ❍Endometrial and endocervical sampling DOS: ___/___/___ If no endometrial pathology: ❍Colposcopy DOS: ___/___/___	❍Treatment referral to OB/GYN *Complete page 4: Cervical Cancer Treatment Section*

❍Consultation or second opinion:	Physician:	Clinic Name:	Date of Service: ___/___/___
❍Client Refused *Initiate: Client Informed Refusal Form/Service Provider Document*		

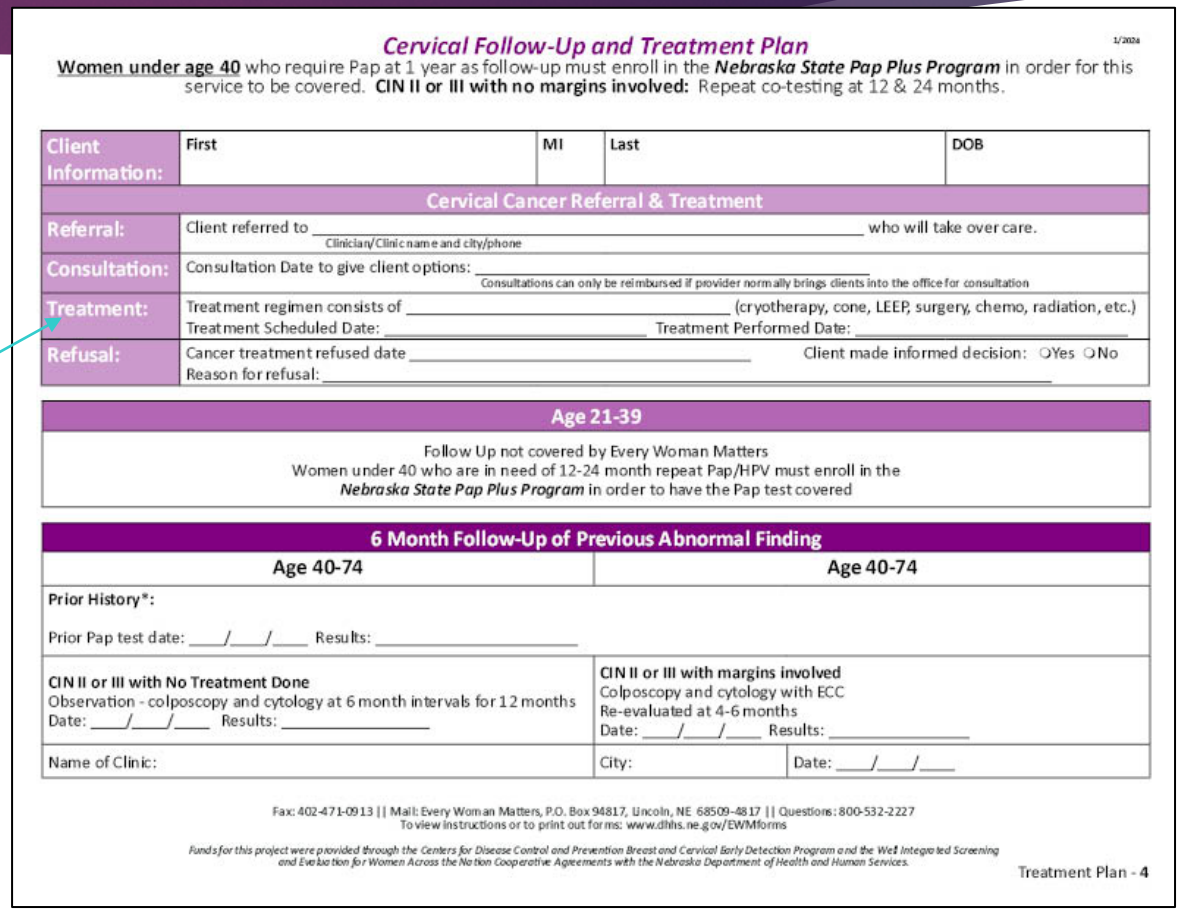
DOS = Date of Service

★ Final Diagnosis: This section must be completed before sending to EWM	Check one:
	❍Normal/Benign Inflammation; HPV/Condylomata/Atypia; Treatment not indicated / Repeat Pap/HPV or Co-test 1 year ❍Inconclusive Results ❍CIN I ❍CIN II ❍CIN III carcinoma in situ ❍Invasive Cancer For CIN II and greater, complete page 4: Cervical Cancer Referral and Treatment Date of final diagnosis or pathology report: ___/___/___

Page 4 – cervical cancer referral and treatment

If client gets diagnosed with Squamous cell carcinoma, CIN II, CIN III, or Invasive Cancer*:

- Mark it on final diagnosis on pg 3
- Indicate type of treatment and where client is being referred (pg 4)
- Fill out Treatment Funds Request Form



Cervical Follow-Up and Treatment Plan 1/2024

Women under age 40 who require Pap at 1 year as follow-up must enroll in the ***Nebraska State Pap Plus Program*** in order for this service to be covered. **CIN II or III with no margins involved:** Repeat co-testing at 12 & 24 months.

Client Information:	First	MI	Last	DOB

Cervical Cancer Referral & Treatment

Referral:	Client referred to _____ (Clinician/Clinic name and city/phone) who will take over care.
Consultation:	Consultation Date to give client options: _____ (Consultations can only be reimbursed if provider normally brings clients into the office for consultation)
Treatment:	Treatment regimen consists of _____ (cryotherapy, cone, LEEP, surgery, chemo, radiation, etc.) Treatment Scheduled Date: _____ Treatment Performed Date: _____
Refusal:	Cancer treatment refused date _____ Client made informed decision: ○Yes ○No Reason for refusal: _____

Age 21-39

Follow Up not covered by Every Woman Matters
Women under 40 who are in need of 12-24 month repeat Pap/HPV must enroll in the ***Nebraska State Pap Plus Program*** in order to have the Pap test covered

6 Month Follow-Up of Previous Abnormal Finding

Age 40-74	Age 40-74
Prior History*: Prior Pap test date: ___/___/___ Results: _____	
CIN II or III with No Treatment Done Observation - colposcopy and cytology at 6 month intervals for 12 months Date: ___/___/___ Results: _____	**CIN II or III with margins involved** Colposcopy and cytology with ECC Re-evaluated at 4-6 months Date: ___/___/___ Results: _____
Name of Clinic:	City: Date: ___/___/___

Fax: 402-471-0913 || Mail: Every Woman Matters, P.O. Box 94817, Lincoln, NE 68509-4817 || Questions: 800-532-2227
To view instructions or to print out forms: www.dhhs.ne.gov/EWMforms

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Treatment Plan - 4

Women's Cancer Program

- If your client gets diagnosed with Squamous cell carcinoma, CIN II or CIN III, or invasive cancer through EWM, by Nebraska state statute she may be eligible for Nebraska Medicaid for LEEP, Cold Knife conization, or other cancer treatment through the Women's Cancer Program (WCP).
  - this treatment Medicaid is specific to our program including EWM income guidelines (250% of Federal Poverty Guidelines)
  - clients with cervical cancer diagnosis have access to WCP Medicaid for 60 days, or 6 months if invasive, or throughout their cervical cancer treatment
  - **We provide the client with the WCP Medicaid application**
  - clients must **not** have adequate health insurance in order to be eligible for Medicaid through Women's Cancer Program
    - If client has insurance that is limited coverage/benefits, we will work with Medicaid to determine if insurance is considered creditable or not. If insurance is deemed not creditable, client may be eligible for WCP.

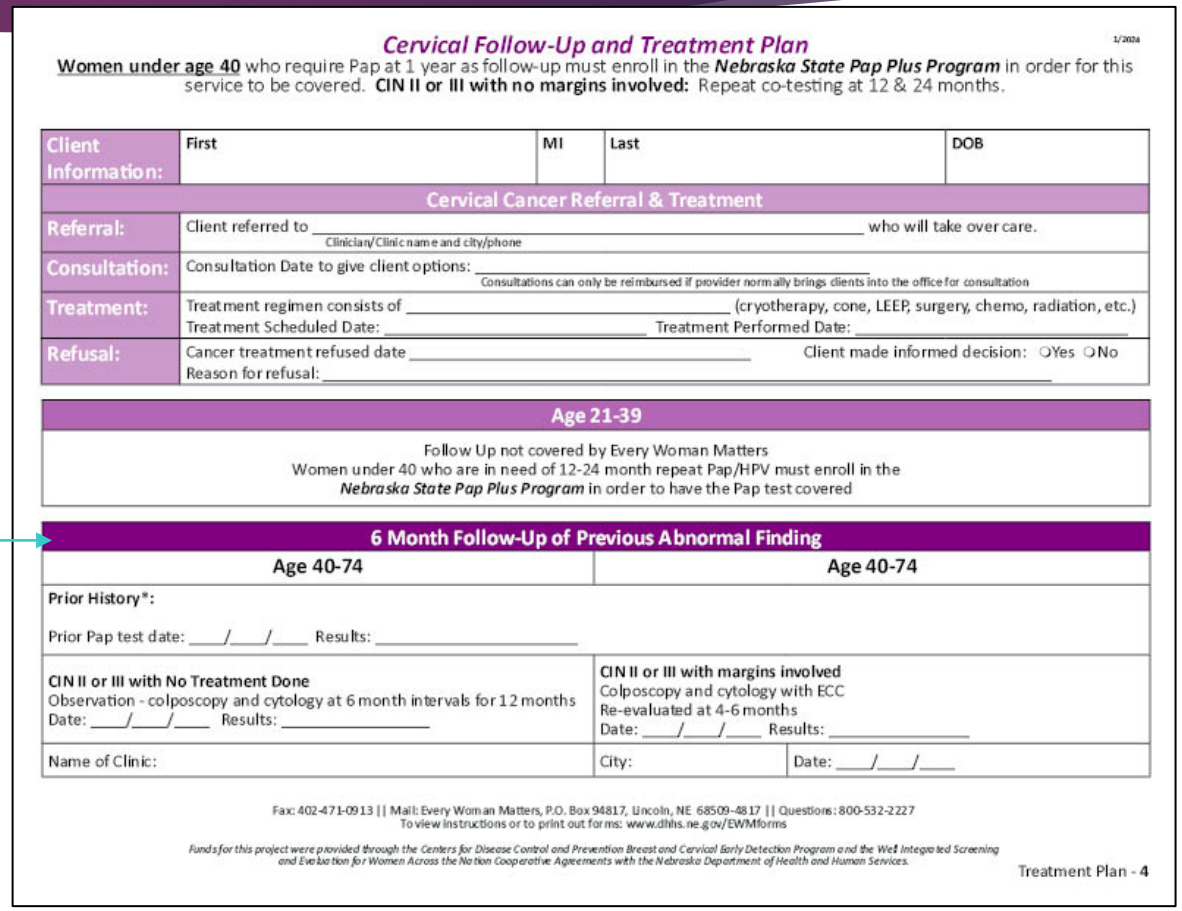
Women's Cancer Program

If client is diagnosed with Squamous cell carcinoma, CIN II or CIN III, or invasive cancer :

- Call EWM at 1-800-532-2227 and ask for the nurse if you have any questions or need to discuss next steps.
- EWM staff will contact client and send out our Medicaid form.
- Although not required, we do appreciate a "heads up" phone call so we can get the process of helping your patient to apply for Medicaid started **as quickly as possible,** as this process takes time.
- Clinic should submit the Treatment Funds Request Form to EWM.

Page 4 – Follow-up of Previous Abnormal Finding

- Only for women who need follow-up **after** a previous abnormal finding (such as CIN II or III)
- Pre-authorization not needed, but must follow ASCCP guidelines.
- Do not fill out page 3, just bottom of page 4 along with clinical documentation
  - Send within 2 weeks of date of service
- 6 month follow up **NOT** allowed for women under age 40



Cervical Follow-Up and Treatment Plan 1/2024

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Cervical Cancer Referral & Treatment

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Age 21-39

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Name of Clinic:	City:	Date: ___/___/___

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Treatment Plan - **4**

Reminders

- Must follow ASCCP guidelines.
- Clients for cervical program must be 21 or older.
- Instructions are no longer printed. Forms and instructions can be found online at www.dhhs.ne.gov/ewmforms. We update forms frequently. Please go to the website for the latest versions.
- We do **NOT** cover:
  - pelvic ultrasounds
  - endometrial biopsies (EMBs) for any reason other than AGC Pap test result
- Forms must be complete, including final diagnosis and providers must submit copies of all diagnostic tests within 2 weeks.
- Call EWM at 1-800-532-2227 if you have questions!

Additional Questions regarding Cervical Diagnostic Enrollment?

Contact an Every Woman Matters representative:

Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/womenshealth web

dhhs.ewm@nebraska.gov email

Every Woman Matters

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DEPT. OF HEALTH AND HUMAN SERVICES