North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
1985 Umstead Drive – 2512 Mail Service Center - Raleigh, N.C. 27699-2512
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Nina M. Yeager, Director
(919) 857-4019

March 6, 2002

Re: Breast and Cervical Cancer Medicaid

Dear County Director of Social Services and County Directors of Public Health Departments:

The purpose of this letter is to inform you of changes that have been made to the DMA-5079, Breast and Cervical Cancer Medicaid application, and the DMA-5081, Verification of Screening, Diagnosis, and Treatment form.

The "Rights and Responsibilities" on page five of the application is revised to include a couple of sentences to inform the Breast and Cervical Cancer Medicaid applicant her Social Security Number will be matched with the Social Security Administration, Internal Revenue Service, Employment Security Commission, out of state Social Services and any other government agencies. If she does not want her SSN matched she has a right to withdraw her application.

The match of her Social Security number does not affect her eligibility for Medicaid in this program but by law the applicant has to be informed her Social Security number will be matched. In January, when this new Medicaid program began, Division of Medical Assistance (DMA) understood the Eligibility Information System would suppress these matches. This was not able to occur.

The DMA-5081, Verification of Screening, Diagnosis and Treatment form, has been revised to assist the BCCCP screening providers in completing the diagnosis and length of treatment for the individual applying for Breast and Cervical Cancer Medicaid.

Attached is the revised "Rights and Responsibilities" and the revised DMA-5081. DMA requests when an application is completed on a Breast or Cervical Cancer Medicaid applicant that the screening provider remove the last page of the application, "Rights and Responsibilities" and replace with this revised "Rights and Responsibilities". Please copy this attachment and ensure it is attached to the DMA-5079's you have on hand.

Please share this information with your staff so they may begin using the revised "Rights and Responsibilities" and revised DMA-5081 with all new Breast and Cervical Cancer Medicaid **applications taken on or after April 1, 2002**. If the BCCCP screening provider is able to use the revised "Rights and Responsibilities" with the DMA-5079 before April 1, 2002, document this on the DMA-5079.

If you have questions regarding Medicaid, please contact the Medicaid Eligibility Unit at (919) 857-4019. If you have questions regarding diagnosis and length of treatment, please contact the Division of Public Health, BCCCP staff, at (919) 715-0119.

Nina M. Yeager

cc: Larry Jenkins, Division of Public Health
BCCCP Coordinators

Breast and Cervical Cancer Medicaid
"Rights and Responsibilities"

Notification of Decision

The State Division of Medical Assistance (DMA), Medicaid Eligibility Unit, will process your application for Breast and Cervical Cancer Medicaid coverage quickly. The sooner you get information we may need to DMA the sooner we can process your application for medical coverage. If additional information is needed you will be contacted by mail or telephone. Be sure to list correct phone numbers and address so you may be contacted.

Your Rights and Responsibilities

Rights:

- Apply for assistance and, if found ineligible may reapply at any time.
- Not be discriminated against because of race, color, national origin, sex, religion, age or disability.
- Have the information you provide kept in confidence.
- Withdraw from the program at any time.
- Receive assistance if found eligible.
- Appeal to the Division of Medical Assistance (State Medicaid Office) for a hearing if:
  - You were denied the right to apply for assistance.
  - You were encouraged to withdraw your application.
  - Your application was denied and you believe the decision is incorrect.
  - You believe your assistance is incorrect based on the state's interpretation of state regulations.
- To ask for help with medical transportation, if found eligible for Breast or Cervical Cancer Medicaid. If transportation is provided, it will be to the nearest appropriate medical provider of your choice, by the least expensive method. To request transportation assistance contact your county department of social services.

Responsibilities:

- I agree to provide all necessary information to help county, state or federal Medicaid agencies determine my eligibility for this program.
- I agree to notify the Division of Medical Assistance (State Medicaid Office) within 10 calendar days of any changes in my address, plans to move, or availability of other health insurance or no longer receiving treatment for cancer. State Medicaid Eligibility Unit can be contacted through the CARE-LINE, toll-free 1-800-662-7030 or for the Raleigh area (919) 857-4019.
- I agree to provide a social security number or apply for a social security number for myself, or anyone for whom I am applying for Medicaid, if one has not been issued. I understand these social security numbers will be used in matching information with the Social Security Administration (SSA), Internal Revenue Service (IRS), Employment Security Commission (ESC), out-of state Social Services and ESC agencies, and any other agencies, when applicable. If I do not want these social security numbers to be used in the matches, I understand I have the right to withdraw my application or have my assistance terminated.
- I certify that the information I have provided is a true and complete statement of facts. I understand that State and Federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance.
- I certify I currently live in North Carolina and intend to remain.

VERIFICATION: SCREENING, DIAGNOSIS AND TREATMENT

BCCCP Coordinator: Please check YES or NO:

_______*Yes* ***This patient has been enrolled in the NC Breast and Cancer Control Program (BCCCP), and has received screening and/or diagnostic testing through the BCCCP.*** *(A √by YES requires that this form be completed by the diagnosing or treating physician.)*

_______*No* ***This patient is not a participant of the BCCCP and has not received screening and/or diagnostic testing through the BCCCP to receive this diagnosis.***
(A √by NO is an indication that the patient is not a candidate for the BCCM. Please call your BCCCP Case Manager for more information.)

♦♦

Name & Telephone Number of Medical Clinic responsible for diagnosis and treatment plan:

____

Patient Name:____

Patient Address:____

Patient SS Number: ______________________ **Date of Birth**___________

Diagnosis Date:____

Diagnosis Confirmed by: Colposcopy____**Biopsy**____**Other**___________

(Pending or unconfirmed diagnoses will result in BCCM denial)

Diagnosis: ____

____

Treatment:____

to begin_____________________________________ (date) **and continue for:**

____.

(Additional certification is required prior to BCCM coverage extending beyond 12 months. Routine breast and /or cervical re-screening should be performed through the BCCCP provider.)

____

Physician Signature **Date**

♦♦

*BCCCP Provider (Agency)*____

*BCCCP Coordinator*________________________*Telephone #*___________________

THIS IS A REQUIRED ATTACHMENT TO THE APPLICATION FOR BREAST & CERVICAL CANCER MEDICAID (BCCM)

DMA-5081
Revised 04/02