NORTHWEST GEORGIA REGIONAL
CANCER COALITION

COLORECTAL CANCER SCREENING FUNDS ELIGIBILITY POLICY & PROCEDURE

Determine income eligibility by using Federal Guidelines for 200% of Poverty + $6528 ($544/month). This guideline is revised July 1 of each year:

1. Effective July 1, 2005, the following chart represents the Federal Poverty guideline for 200% + $6528 ($544/month). For family units with more than 8 members, add $6,528 to the yearly income for each additional family member.

2. NWGRCC Eligibility Guidelines:

Family Unit Size	Monthly Income	Yearly Income
1	$2,139	$25,668
2	$2,683	$32,196
3	$3,227	$38,724
4	$3,771	$45,252
5	$4,315	$51,780
6	$4,859	$58,308
7	$5,403	$64,836
8	$5,947	$71,364

3. See BCCP Policy & Procedure Manual, Section III, Policy No.1, Page 8, for Family Unit Guidelines.

4. Eligibility:
   - Individuals with family history of Colorectal Cancer;
   - Individuals between age 50 – 64;
   - Individuals ineligible for any other type of public assistance;
   - Individuals who are uninsured or whose insurance does ***not*** cover colonoscopy for colorectal cancer screening, who are financially eligible according to the above schedule.

5. Covered Services:
   - Colonoscopy
   - Prep Medicines
   - Transportation to an appropriate facility (up to $10) for the colonoscopy

COLONOSCOPY PROGRAM

FINANCIAL ELIGIBILITY WORKSHEET

Client Name: ___________________________________

Family Size: ___________

Maximum Qualifying **Monthly** Income for Family Size (see NWGRCC Eligibility Guidelines)	$
Gross **Monthly** Family Income (see * below)	$
Eligible? Yes No (circle one) (If no, continue.)	
Total monthly income credit for on-going (monthly) medical expenses (medications, medical supplies, laboratory costs, physician's visits, health insurance premiums)	$
Monthly income after medical expenses deducted	$
Eligible? Yes No (circle one) (If no, continue.)	
Maximum Qualifying **Annual** Income for Family Size	$
Gross **Annual** Family Income	$
Total outstanding medical debt owed (medical expenses owed by applicant and family members after all other resources have paid)	$
Annual Family Income after medical debt deducted	$
Eligible? Yes No (circle one)	
If **Yes**, client qualifies for program. If **No**, client does not qualify	

* Income generated /received by family members counted in the household size
Income reported bi-weekly: multiply by 2.16 to determine monthly income
Income reported weekly: multiply by 4.33 to determine monthly income
Income reported annually: divide by 12 to determine monthly income

Financially Eligible: **Yes ______** **No _______**

Person Completing Form: _____________________________

Organization: ___________________________________

Date: ___________

Northwest Georgia Regional Cancer Coalition Colorectal Referral Form

Complete Top Portion and return along with the Financial Eligibility Worksheet to the NWGRCC at 96 East Callahan St., Suite 479-01 Rome, GA 30161

County _____________ **Date of Visit/Referral** _______________________

Referring Organization ______________________

Name of Referring Person ____________________

Patient Name ________________________________

Address ____
Street **City** **Zip**

Phone __________________________ **DOB** ________________________ **Age** ___

Gender M __ F __ **Race** White __ African-American __ Hispanic/Latino __ Other _____________

Yearly Family Income Equal to or Below Guidelines? Yes __ No __

Health Insurance? Yes __ No __

Special Needs? Yes__ No __
If yes, what? ____

Transportation? Yes __ No __
If No: Need stipend to pay for transportation? Yes __ No __
Needs transportation arranged? Yes __ No __

I authorize the health department and other providers and the facility performing my colonoscopy to release my medical record(s) to my referring physician and/or other physician(s) treating me. Further, I authorize the facility and my treating physician(s) to release my medical report(s) to the Northwest Georgia Regional Cancer Coalition and other providers for statistical, billing and follow-up purposes. I understand that the colonoscopy will be done at no cost to me.

____ _________________________
Printed Name/Patient Signature Date

____ __________________________
Printed name/signature of referring person Date

For NWGRCC Only:

Date Received by NWGRCC ____________________
Date Reviewed by NWGRCC ____________________

APPROVED __________________
Date

DENIED _________________
Date

Referred to:

Gordon Hospital ____
Magnolia Foundation ____

Northwest Georgia Regional Cancer Coalition, Inc.

Colonoscopy Screening Form

_________ County H. D.

Patient Name:____
First Middle Initial Last

Address: ____
Street City Zip

County of Residence ________________ **Phone Number** ________________________________

Date of Birth _________________ **Age** _______ **Social Security Number**_________________________

Previous colonoscopy? Yes __ No __
If yes, how long ago? ____
Results? ____
Family history of CRC? Yes __ No __
If yes, relationship ____
What age at diagnosis? __________________________________
Current symptoms?
Yes __ No __ Unknown __

For Clinical Staff Only:

Clinical Assessment

Date of Colonoscopy __________

Facility:
Floyd Medical Center __
Redmond Regional Medical Center __
Gordon Hospital ___

Provider Group:
Harbin Clinic Gastroenterology __
Rome Gastroenterology Associates __
Northwest Georgia Surgical Associates __

Physician __________________________________

Financial Responsibility

Paid for by: NWGRCC ___
Magnolia ____

Prep Medications:
Pharmacy ________________
name

Colonoscopy Results (Check only one)

__ Assessment is incomplete
__ Negative
__ Benign Finding
__ Probably Benign – short screening interval
__ Suspicious abnormality
__ Highly Suggestive
__ Unsatisfactory
__ Not needed
__ Needed but not performed (refused)
__ Result unknown, presumed abnormal

Pathology Results (Check only one)

__ Benign finding
__ Abnormal

If abnormal, diagnosis and stage:
____
____
____

Referral Needed? Yes __ No __
To: ________________________

Follow up colonoscopy needed? Yes __ No __
If yes, When? ___________

Return to NWGRCC, 96 East Callahan St, Suite 479-01, Rome, GA 30161