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:

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


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: ____________

<table>
<thead>
<tr>
<th>Maximum Qualifying <strong>Monthly</strong> Income for Family Size (see NWGRCC Eligibility Guidelines)</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross <strong>Monthly</strong> Family Income (see * below)</td>
<td>$</td>
</tr>
<tr>
<td>Eligible? Yes No (circle one) (If no, continue.)</td>
<td></td>
</tr>
<tr>
<td>Total monthly income credit for on-going (monthly) medical expenses (medications, medical supplies, laboratory costs, physician’s visits, health insurance premiums)</td>
<td>$</td>
</tr>
<tr>
<td>Monthly income after medical expenses deducted</td>
<td>$</td>
</tr>
<tr>
<td>Eligible? Yes No (circle one) (If no, continue.)</td>
<td></td>
</tr>
<tr>
<td>Maximum Qualifying <strong>Annual</strong> Income for Family Size</td>
<td>$</td>
</tr>
<tr>
<td>Gross <strong>Annual</strong> Family Income</td>
<td>$</td>
</tr>
<tr>
<td>Total outstanding medical debt owed (medical expenses owed by applicant and family members after all other resources have paid)</td>
<td>$</td>
</tr>
<tr>
<td><strong>Annual</strong> Family Income after medical debt deducted</td>
<td>$</td>
</tr>
<tr>
<td>Eligible? Yes No (circle one)</td>
<td></td>
</tr>
</tbody>
</table>

* 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 __________________     Referred to:

Date

DENIED __________________             Gordon Hospital ___

Date          Magnolia Foundation ____

Northwest Georgia Regional Cancer Coalition, Inc.
Colonoscopy Screening Form

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

Physician _______________________________________________________

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:

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

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