



VERMONT DEPARTMENT
OF HEALTH

www.LadiesFirstVt.org

Application Instructions

Thank you for your interest in the Ladies First program. The Ladies First program offers free mammograms, Pap tests, and screenings for cholesterol, blood pressure, and diabetes. Also, Ladies First offers free personalized nutrition plans, help with eating and weight loss, and help to quit smoking.

To Apply:

1. Please complete the entire Application and sign and date.
2. Mail to:

Vermont Department of Health
PO Box 70
Drawer 38 (LF)
Burlington, VT 05402-0070

Once Ladies First receives your **completed** application, it will be processed to determine your eligibility. If you are found eligible for the program, you will receive a Ladies First brochure explaining Ladies First services, a membership card, and a Health Exam Check-up form to bring to your appointment.

Sincerely,

Ladies First

If you have any questions, please call Kate at 1-800-508-2222.



Ladies First offers FREE:

Mammograms, Pap tests,
and screenings for cholesterol,
blood pressure, and diabetes.

Ladies First membership is based on:

- Vermont residency
- age
- number in household*
- income

Gross income for 2011 *(before taxes)*

Number in household*	Yearly	Monthly
1	\$27,225	\$2,269
2	\$36,775	\$3,065
3	\$46,325	\$3,860
4	\$55,875	\$4,656
5	\$65,425	\$5,452

* Anyone living in the household that is related by marriage, civil union, or a dependent child related by birth or adoption. For additional family members, add approximately \$9,550 yearly and \$796 monthly.

**Ladies
First**

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Call Kate today at
1-800-508-2222

For Deaf and Hard of Hearing individuals,
please use Vermont Relay Service 711
and give our number: **1-800-508-2222**.

For women age 40 and over, or age 21–39 with abnormal Pap and age 18–39 with breast symptoms



Ladies First pays for:

BREAST

- breast exam
- breast self-exam instruction
- mammogram (breast x-ray)
- more tests as needed

CERVICAL

- pelvic exam
- Pap test
- more tests as needed

HEART HEALTH

- blood pressure
- cholesterol
- height and weight
- diabetes test
- help with nutrition, physical activity and quitting smoking



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Call Kate today at 1-800-508-2222

Ladies First members will be referred for full Medicaid coverage if breast or cervical treatment is needed. Members can have private health insurance including Catamount. If you have insurance, your insurer must be billed first and you will be responsible for any co-pays and deductibles that apply. Ladies First is unable to enroll or cover women who have VHAP, Medicaid or Medicare Part B. VHAP, Medicaid and Medicare Part B offer these check-ups.



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Application

All information must be provided. Please print in ink, or type.



Section 1: Applicant's Information

NAME (Legal or as it appears on Social Security Card):		DATE OF BIRTH:	SOCIAL SECURITY NO.
		E-MAIL ADDRESS:	
STREET ADDRESS (REQUIRED):		PRIMARY PHONE NO.: (<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL) () _____ - _____	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):		IS IT OK TO LEAVE A MESSAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No BEST TIME TO REACH YOU? <input type="checkbox"/> Anytime <input type="checkbox"/> 9:00-11:00 <input type="checkbox"/> 11:00-1:00 <input type="checkbox"/> 1:00-3:00 <input type="checkbox"/> 3:00-5:00 <input type="checkbox"/> After 5:00	
RESIDENTIAL STATUS Vermont Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No US Citizen or Resident Alien Status? <input type="checkbox"/> Yes <input type="checkbox"/> No		ALTERNATIVE PHONE: (<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL) () _____ - _____	
ARE YOU OF LATINO OR HISPANIC ORIGIN? <input type="checkbox"/> Yes <input type="checkbox"/> No		WHAT IS THE HIGHEST SCHOOL GRADE EVER COMPLETED? <input type="checkbox"/> Never attended school, or only kindergarten <input type="checkbox"/> Grades 1-8 (elementary) <input type="checkbox"/> Grades 9-11 (some high school) <input type="checkbox"/> Grade 12 or GED (High school graduate) <input type="checkbox"/> College 1 to 3 years (or technical school) <input type="checkbox"/> College 4 years or more (college graduate) <input type="checkbox"/> Do not know <input type="checkbox"/> Do not want to answer	
WHAT RACE OR RACES DO YOU CONSIDER YOURSELF?			
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> Do not want to answer			
NUMBER OF PEOPLE IN YOUR HOUSEHOLD.			
PLEASE INCLUDE YOU, SPOUSE/CIVIL UNION PARTNER, DEPENDENT CHILD(REN) _____			
GROSS HOUSEHOLD INCOME (BEFORE TAXES) \$ _____ /YEAR OR \$ _____ /MONTH (GROSS WEEKLY x 4.3)			

Section 2: Health History

IS THIS YOUR FIRST PAP TEST? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "NO", list the approximate dates of your last two Pap tests.	
DATE: ____/____/____	PRACTICE NAME: _____
DATE: ____/____/____	PRACTICE NAME: _____
IS THIS YOUR FIRST MAMMOGRAM? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "NO", list the approximate dates of your last two mammograms.	
DATE: ____/____/____	PRACTICE NAME: _____
DATE: ____/____/____	PRACTICE NAME: _____
WHEN WAS YOUR CHOLESTEROL LAST CHECKED?	
DATE: ____/____/____	OR <input type="checkbox"/> Never PRACTICE NAME: _____
DO YOU SMOKE CIGARETTES? <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all <input type="checkbox"/> Don't know <input type="checkbox"/> Don't want to answer	
If so, could we make a referral to the "QUITLINE" for you? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Health History Con't

1. Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?

- Yes
- No
- Don't know
- Don't want to answer

2. Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?

- Yes
- No
- Don't know
- Don't want to answer

3. Have you ever been told by a doctor, nurse, or other health professional that you have diabetes?

- Yes
- No
- Yes — Gestational (pregnancy) diabetes
- Don't know
- Don't want to answer

4. Has a doctor, nurse, or other health professional ever told you that you had any of the following: heart attack (also called myocardial infarction), angina, coronary heart disease, or stroke?

- Yes
- No
- Don't know
- Don't want to answer

5. Has your father, brother, or son had a stroke or heart attack before age 55?

- Yes
- No
- Don't know
- Don't want to answer

6. Has your mother, sister, or daughter had a stroke or heart attack before age 55?

- Yes
- No
- Don't know
- Don't want to answer

7. Has either of your parents, your brother or sister, or your child ever been told by a doctor, nurse or other health professional that he or she has diabetes?

- | | |
|------------|----------------------|
| Yes | No |
| Don't Know | Don't want to answer |

8. Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your high cholesterol?

- Yes
- No
- Don't know/ Not sure
- Don't want to answer

9. Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your high blood pressure?

- Yes
- No
- Don't know/ Not sure
- Don't want to answer

10. Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your diabetes?

- Yes
- No
- Don't know/ Not sure
- Don't want to answer

11. Do you now smoke cigarettes every day, some days or not at all?

- Every day
- Some days
- Not at all
- Don't know/ Not sure
- Don't want to answer

12. Not counting decks, porches, or garages, during the past 7 days, on how many days did someone other than you smoke tobacco inside your home while you were home?

- | | | | | | | | |
|----------------------|---|---|---|---|---|---|---|
| Zero | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Don't know | | | | | | | |
| Don't want to answer | | | | | | | |

13. How many days per week do you participate in moderate physical activity for at least 30 minutes? (For example, brisk walking, bicycling, vacuuming or gardening.) Please circle number of days.

- | | | | | | | | |
|------|---|---|---|---|---|---|---|
| Zero | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|------|---|---|---|---|---|---|---|

14. How many CUPS of fruit do you eat each day?

- | | | | | | | |
|------|---|---|---|---|---|-----------|
| Zero | 1 | 2 | 3 | 4 | 5 | 6 or more |
|------|---|---|---|---|---|-----------|

15. How many CUPS of vegetables do you eat each day?

- | | | | | | | |
|------|---|---|---|---|---|-----------|
| Zero | 1 | 2 | 3 | 4 | 5 | 6 or more |
|------|---|---|---|---|---|-----------|

Section 3: Health Insurance Information (Please, complete if applicable)

I DO NOT HAVE HEALTH INSURANCE I RECENTLY APPLIED FOR HEALTH INSURANCE

DO YOU CURRENTLY HAVE: VHAP/Medicaid Medicare Part B **HAVE YOU RECENTLY APPLIED FOR:** VHAP/Medicaid

NAME OF COMPANY:

COVERAGE TYPE:

INSURANCE COMPANY'S MAILING ADDRESS:

COVERAGE START DATE (MUST HAVE): _____ **UNTIL** _____ **(LEAVE BLANK IF THERE IS NO ENDING DATE)**

POLICY HOLDER'S NAME:

SOCIAL SECURITY NO.:

POLICY OR ID NUMBER:

GROUP OR ACCOUNT NUMBER:

Section 4: Transportation, Childcare, Eldercare & How Did You Hear?

DO YOU NEED A RIDE TO YOUR LADIES FIRST APPOINTMENT? Yes No

DO YOU NEED CHILDCARE/ELDERCARE WHILE YOU ATTEND YOUR LADIES FIRST APPOINTMENT? Yes No

HOW DID YOU LEARN ABOUT THE LADIES FIRST PROGRAM?

- Your doctor, nurse or medical clinic Friend, relative or acquaintance Pamphlet or poster Special Promotion
 TV Newspaper Former Member Ladies First website Other _____

Section 5: Member Consent - Rights and Responsibilities

When you join Ladies First, you give us permission to share information about your breast and cervical cancer screenings, heart disease risk factor screening (for woman 40 and over), and diagnosis and treatment care with:

- Your doctor or nurse
- The Vermont Mammography Registry
- The Vermont Cancer Registry
- The Vermont Medicaid Program (if you are referred to this program by us)
- Hospitals, clinics, health care providers involved in your tests or treatment
- Centers for Disease Control and Prevention, National Breast and Cervical Cancer Early Detection Program and Wisewoman Program

Ladies First must collect and share information about your screenings, follow-up tests, and treatment to make sure you are getting the care you need. We also need this information to pay your medical bills.

Ladies First will keep this information private. We will share your personal information only with the people listed above. It is not public information and it will only be used to make sure you get appropriate, quality health care.

You do not have to join Ladies First. If you do, you can leave at any time. When you leave the program, the Department of Health will no longer have permission to share information about your care. To leave Ladies First, you need to write a letter and send it to: **Vermont Department of Health, PO Box 70, Drawer 38, Burlington, VT 05402-9962**

Ladies First members can have private health insurance including Catamount. If you have insurance, your insurer must be billed first and you will be responsible for any co-pays and deductibles that apply. Ladies First is unable to enroll or cover women who have VHAP, Medicaid or Medicare Part B; however, VHAP, Medicaid and Medicare Part B offer these check-ups.

It is required that you write to us within 30 days if you; 1. obtain private health insurance; 2. end your existing private health insurance; 3. move out of state; 4. start receiving Medicaid, VHAP or Medicare Part B coverage or 5. change your legal name, street address, or mailing address. If we are not informed you may receive a bill.

I have read this form. By signing here, I understand and agree that three months retroactive to the date signed below, the Ladies First program may exchange information about me as described above as long as I am part of this program.

SIGNATURE:

DATE:

Questions? Call Kate at 1-800-508-2222 • www.LadiesFirstVt.org

NOTICE OF PRIVACY PRACTICES
VERMONT DEPARTMENT OF HEALTH
Ladies First Program

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

Our Duties

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all medical information we maintain. A copy of the revised notice is available from our website at healthvermont.gov, the Health Department District Offices, our Privacy Coordinator by calling 802-865-7748, or by writing to the Vermont Department of Health, Division of Health Promotion and Disease Prevention, 108 Cherry Street, P.O. Box 70, Drawer 38, Attention: Privacy Coordinator. You may also address questions regarding our privacy practices, your privacy rights, or requests for additional information regarding your privacy to this person.

Section 1: Permitted Uses

We may use and disclose your medical information for specific reasons:

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information.
- **Payment:** Protected health information will be used to bill your insurance company, or another person that may be responsible for payment of your account. We may need to contact your health plan to see if they will pay for the specified services.
- **Health Care Operations:** We routinely review health information to maintain quality assurance goals, employee reviews, licensing, and marketing activities or other business activities. We may also share your information with contracted third party "business associates" that perform services for the program. The contract requires that they will protect the privacy of your protected health information.

Section 2: Uses and Disclosures That May be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use of disclose of all or part of your protected health information. For instance, an insurance company may request your health information so you can buy insurance. You must authorize the release of the information. Other examples are in facility directories, to others involved in your health care, in emergencies, and if there is a communication barrier that prevents authorization being made.

Section 3: Disclosures Without Authorization

We may use and disclose medical information about you, without your specific authorization:

- **Disclosures Required by Law:** We may be required by federal, state or local law to disclose your medical information.
- **Public Health Activities:** We may disclose your medical information to a public agency, such as the Food and Drug Administration (FDA), for the purpose of controlling disease, injury, or disability.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may be required to disclose your medical information to a public health authority authorized by law to receive the information if we feel that you have been abused or neglected.
- **Health Oversight Activities:** We may be required to disclose your medical information to a health oversight agency for activities authorized by law such as audits, investigations, and inspections.
- **Judicial and Administrative Proceedings:** We may have to disclose your medical information if we receive a subpoena from a judge or administrative tribunal. Substance abuse treatment information will not be released without a court order.
- **Law Enforcement:** We may have to disclose your medical information in conjunction with a criminal investigation by a federal, state or law enforcement agency.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose your medical information for identification, to determine cause of death, or to allow a funeral director to carry out their duties. Information may also be disclosed for eye or tissue donation purposes.

- **Research:** We may disclose your medical information to researchers when their research has been approved by a review board and has established protocols to ensure the privacy of your medical information.
- **Serious Threats to Health or Safety:** We may be required to disclose your medical information if, in our opinion, doing so will help avert a serious threat to the public.
- **Military Activities and National Security:** We may disclose your medical information to the appropriate command authorities.
- **Inmates:** We may use or disclose your medical information if you are an inmate and the information was created or received in the course of providing care to you.
- **Government Programs:** Your medical information may be shared with other state programs and departments that also provide services or payment for services, such as Medicaid, or to coordinate services between government agencies.
- **Worker's Compensation:** We may disclose your medical information to comply with laws regarding worker's compensation.

Section 4: Your Rights

You have certain rights with respect to your medical information.

- **Inspect and Copy:** You may request access to inspect and copy your medical information maintained in our records, including medical and billing records. Your request must be in writing. We will act on your request within 30 days of receipt. If we must deny your request we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for this service.
- **Requesting Restrictions:** You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we agree to it, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request 1) be in writing, 2) describe the information that you want restricted, 3) state if the restriction is to limit or use or disclosure, and 4) state to whom the restriction applies. Requests must be sent to the address on the first page of this notice.
- **Confidential Communications:** You may ask that we communicate with you in a particular way, or at a certain location, to maintain your confidentiality. Your request must be in writing and must tell us how you intend to satisfy your financial responsibility and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request.
- **Amendment:** You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if we did not create the information.
- **Accounting of Disclosures:** You may request a list of disclosures that we have made of your medical information over the previous six (6) years. You may not request an accounting for dates of services prior to April 14, 2003. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period.
- **Paper Copy of this Notice:** You are entitled to receive a paper copy of our Notice of Privacy Practices by using the contact information supplied on the first page.
- **File a Complaint:** If you believe that we have violated your privacy rights, you may file a complaint directly with us using the contact information on the first page. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for complaining.
- **Provide an Authorization for Other Uses and Disclosures:** We will request your written authorization for uses and disclosures of your medical information that are not identified in this notice or permitted by law. You may revoke your authorization at any time in writing.

Effective Date: April 14, 2003