The ________________________________ (Agency) is offering the Michigan Colorectal Cancer Early Detection Program to eligible, low income men and women who are age 50-64, uninsured or underinsured, at average or increased risk for colorectal cancer and not currently enrolled in the Healthy Michigan Plan.

Purpose of the Michigan Colorectal Cancer Early Detection Program
The purpose of the Program is to prevent or find out if I have cancer of the colon or the rectum (gut or colorectal cancer). Regular cancer screening tests can help find a cancer early, when it is still very treatable. If cancer is found before it spreads to other parts of the body, my chances for survival are much better. If cancer is found, I will be helped to find cancer treatment.

What Will I Get From the Program?
1. Colonoscopy
   • The program provides a colonoscopy which is a screening test for cancer of the colon (gut and rectum).

2. Fecal Immunochemical Test (FIT) At-Home-Test
   • If I am at average risk for colorectal cancer, I may choose to complete a FIT test every year at-home instead. The test checks for blood in my stool (poop) that I may not be able to see with my eyes. Within a week, I must use a special "kit" to collect a small sample of stool, and immediately mail the sample to the lab in the special envelope provided in the kit.
   • Blood in my stool is not normal. It can be there because of cancer or because of other problems.
   • If the FIT kit finds blood in my stool, I understand I will also need a colonoscopy. A colonoscopy is necessary and must be completed to determine why there is blood in my stool.

What Will the Program Cost Me? INITIALS __________.
• The Program will pay for a colonoscopy and a "prep" to clean out my gut before the test.
• The Program will pay for biopsies and to have polyps (small mushroom-like growths) removed during the colonoscopy, if needed. There may be other costs not covered by this program.
• My provider may want me to get other tests or services not covered by the Program; these tests will not be paid by the Program. If I agree to get these other tests, I will have to pay for these extra tests or services myself. I understand that I can ask program staff any questions I have about what is paid for by the program.
• The program will also pay for the FIT stool test for colorectal cancer screening if I am at average risk for colorectal cancer. If blood is found in my stool, I will need a second test, a colonoscopy. The staff will help schedule the colonoscopy and the MCRCEDP will pay for this necessary test.

When I enroll in the Program, I will be asked if I have health insurance. I am eligible to receive Program services only if am uninsured or underinsured and not enrolled in the Healthy MI Plan.
• If I receive program services and I did not tell the truth about my insurance status, I will be responsible for all costs of program services that I have received.
What Happens If My Tests Are Not Normal?  

- If I have a test that is not normal, my provider will tell me what test they think I need next. It is my choice to have more tests.
- If I have another provider, I can give the Program written permission to send my test results to the provider.

What if I have Colorectal Cancer?  

- I understand the Program does not pay for treatment for colorectal cancer such as, but not limited to: Surgery, Chemotherapy, Radiation, Medications, or Home Health Care.
- If colorectal cancer is found, the Program staff will help me find a provider and cancer treatment.
- If I cannot pay for follow-up services or cancer treatment, the Program staff will work with me to help me find the services I need.

Things I need to Know about the Screening Tests  

- The risks associated with the screening tests are low, but do exist.
- The MCRCEDP staff, providers and their staff will answer my questions about screening tests and risks.
- I may ask questions at any time.
- No screening test is 100% correct. Screening tests can sometimes miss something that is not normal. Sometimes tests may think something is a problem when it is OK.
- It is important that I receive screenings regularly. Cancer can develop later even if my test results today are normal.
- If my screening test is not normal, it does not always mean that I have cancer. After more tests, only some men and women will be diagnosed with cancer.

I AGREE TO:  

- Follow the Program staff’s directions and complete the FIT.
- Follow the Program staff’s directions and complete the prep and colonoscopy.
- Be contacted when it is time to schedule my next screening appointment.
- Repeat these screening tests at the times the provider thinks is best.
- Be contacted if more testing or appointments are necessary.

I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll. The (Agency) phone number is (_______/_________-___________)

Signature of Client          Date

Signature of Person Obtaining Informed Consent          Date

CONTENTS OF THIS FORM REMAIN IN EFFECT UNTIL MY NEXT ANNUAL VISIT  
MICHIGAN COLORECTAL CANCER EARLY DETECTION PROGRAM
I UNDERSTAND THAT:

- Any personal information found about me will be kept confidential.
- Only information about me that does not identify me will be used in grouped reports or for other scientific purposes concerned with controlling colorectal cancer.
- I may be asked some time in the next several years to answer questions about my colorectal health, or my experiences with this screening program. I understand I am not required to answer such questions. If I do, I do not have to identify myself.

I GIVE PERMISSION AND AGREE TO:

- Provide the Program Agency with information about me, including my health history and reports of screening and diagnostic tests and procedures relating to colorectal cancer.
- Allow the Program Agency to give information regarding my care to:
  - My physician/health care provider
  - Any consulting physician
  - Any clinic or hospital where I may be referred
  - Any other individual chosen by me
  - The Michigan Department of Health and Human Services and other State Of Michigan departments.

I have been able to ask questions about this program and this form, and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll in the MCRCEDP. The MCRCEDP Agency phone number is (_____/_______-_________).

Signature of client ______________________________ date ______________________________

Signature of person obtaining informed consent ______________________________ date ______________________________

CONTENTS OF THIS FORM REMAIN IN EFFECT ONE YEAR FROM DATE SIGNED