

	<b>Every Woman Counts (EWC) Data Request Form</b>	
	Complete the two-page form and sign the two-page Public Use of Data Agreement, using "tab" to advance. Submit the completed Data Request Form and signed Agreement by email to EWCDMU@dhcs.ca.gov, listing "Data Request" in the subject line, or by fax to (916) 440-5631. Please respond promptly to program analysts; failure to respond within 30 days cancels the request.	
<b>Questions?</b> Please contact your EWC Clinical Coordinator or call (916) 449-5300.		
<b><sup>1</sup>Requestor's Name</b>		<b><sup>2</sup>Title</b>
<b><sup>3</sup>Organization</b>		
<b><sup>4</sup>Organization Email</b>		<b><sup>5</sup>Phone</b>
<b><sup>6</sup>National Provider Identification (NPI)</b>		
<b><sup>7</sup>Mark your affiliation with the Every Woman Counts Program</b>		
<input type="checkbox"/> Primary Care Provider		
<input type="checkbox"/> Advisory Council Member / Stakeholder		
<input type="checkbox"/> Not affiliated with EWC; more information will be needed at the end of the form.		
<b>Specify Due Date (allow 10 or more business days for standard reports)</b>		
<b><sup>8</sup>Date of Request</b>		<b><sup>9</sup>Completion Date</b>
<b>Time Period of Data</b>		
<b><sup>10</sup>Begins</b>		<b><sup>11</sup>Ends</b>
Each standard report covers a single provider. Reports of incomplete or abnormal cycles are generated as separate reports for breast or cervical cycles. Recipients are identified by their EWC number and birthdate as month / year.		
<b><sup>12</sup>Mark chosen standard reports</b>		
<input type="checkbox"/> Enrolled Recipients (first day of enrollment occurs in the specified period)		
<input type="checkbox"/> Enrolled Recipients with Incomplete Cycles (specified work-up is incomplete)		
<input type="checkbox"/> Enrolled Recipients with Abnormal Cycles (unclear or abnormal results)		

<b><sup>13</sup>If other than a standard report is needed, please summarize your request below. Attach additional pages as needed.</b>		
<b><sup>14</sup>Tell us how the data will be used; mark response or describe below.</b>		
	Track EWC data submission	
	Track cases of DCIS <sup>1</sup> , LCIS <sup>2</sup> , invasive breast cancer and / or cervical cancer	
	Track service and/or case management claims	
	Audits and Investigations or Legal documentation	
	Grant application, policy development, program planning, budgeting	
	Program evaluation or research	
	<sup>15</sup> Other use, including presentation. Summarize below; attach pages as needed.	
<b><sup>16</sup>Are you requesting this data for someone else?</b>		
No		Yes
<b>If yes, provide the requestor's contact information below.</b>		
<sup>17</sup> Name	<sup>18</sup> Title	
<sup>19</sup> Organization	<sup>20</sup> Phone	
<sup>21</sup> Organization Email		
<b><sup>22</sup>If not a provider, advisory board or stakeholder, please state your interest in Every Woman Counts program data. Attach pages as needed.</b>		
<sup>23</sup> Mailing Address		
<sup>25</sup> City	<sup>26</sup> State	<sup>27</sup> Zip Code

<sup>1</sup> DCIS is ductal carcinoma in situ (also called intraductal carcinoma)

<sup>2</sup> LCIS is lobular carcinoma in situ

Please Note: Any information that can be used to identify an *Every Woman Counts* client is Protected Health Information (P.H.I.) under the federal Health Insurance Portability and Accountability Act (H.I.P.A.A.). Cancer Detection and Treatment Branch (C.D.T.B.) will only release P.H.I. on the basis of a demonstrated need to know, a signed confidentiality agreement or a healthcare services provider agreement, and with the approval of the affected client or designee.

### **Public Use of Data Agreement**

**By the signature below, I, the requestor, agree to abide by the following provisions regarding use of California Cancer Detection and Treatment Branch (C.D.T.B.) data:**

- Original C.D.T.B. data is released "as is." Neither C.D.T.B., Benefits Division, nor the California Department of Health Care Services (D.H.C.S.), or any of their respective divisions or subdivisions, make any representations, express or implied, about data completeness or accuracy, or fitness of the data for a particular purpose.
- Requestors assert that technical descriptions of the data published or distributed are consistent with those provided by C.D.T.B. Consultations with C.D.T.B. staff to discuss uses and limitations of the data are encouraged.
- The data provided is only to be used for the purposes stated in the data request form, unless the Requestors obtain prior written approval.
- C.D.T.B. data is for the exclusive use of the individual requesting the data. The requestor will not alter, share, release or redistribute original C.D.T.B. data.
- Public communications must include a disclaimer attributing the Requestor's own interpretations or opinions to the authors and not to C.D.T.B.
- All publications using the information provided must acknowledge the California Department of Health Care Services, Cancer Detection and Treatment Branch (D.H.C.S. / C.D.T.B.) as the original source of material.
- Requestors will notify C.D.T.B. of all writings, public communications and /or presentations, including but not limited to published articles, accepted abstracts, academic papers, and conference presentations or papers, that include or are based on C.D.T.B. data.
- Requestors agree to send to C.D.T.B. one (1) copy of any public communication or publication derived from the information requested.

- Research requests for de-identified products of analysis may require approval of the Department of Public Health Committee for the Protection of Human Subjects (C.P.H.S.). The C.P.H.S. may be contacted at 1600 Ninth Street, Room 432, Sacramento, CA 95814, telephone (916) 653-0176.
- Requestors agree not to use de-identified data to determine the identity of individual persons. Attempting to determine individual identities from public data is a violation of the federal Privacy Act, 5 U.S.C. and the H.I.P.A.A. Privacy Rule.

**"Protected Health Information" or "P.H.I." means any information, whether oral or recorded in any form or medium that relates to the past, present, or future physical or mental condition of an individual, the provision of health and dental care to an individual, or the past, present, or future payment for the provision of health and dental care to an individual; and that identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. P.H.I. shall have the meaning given to such term under H.I.P.A.A. and H.I.P.A.A. regulations.**

- D.H.C.S. and our Clinicians and Primary Care and Referral Providers agree to protect the privacy and provide for the security of P.H.I. created, received, maintained, transmitted, used or disclosed pursuant to agreements under separate cover, in compliance with H.I.P.A.A. and H.I.P.A.A. regulations and other applicable laws.
- Computer or paper files containing P.H.I. must be protected under lock and key and/or by encryption, and must be destroyed upon completion of all analyses pertaining to each request.
- Requestors are not authorized to release any of the data containing P.H.I. to a third party.

**<sup>28</sup> Signature** \_\_\_\_\_

**<sup>29</sup> Type or print name** \_\_\_\_\_

**<sup>30</sup> Date** \_\_\_\_\_

1. Enter the Requestor's Name.
2. Enter the Requestor's Title.
3. Enter the Requestor's Organization.
4. Enter the Requestor's Organization Email Address.
5. Enter the Requestor's Telephone Number.
6. Enter National Provider Identification Number (NPI)
7. Mark your affiliation with the Every Woman Counts Program Check the appropriate box(es).
8. Enter the Date of Request as xx/xx/xx month/day/year.
9. Enter the Desired Completion Date as xx/xx/xx month/day/year. Allow 10 or more business days for completion.
10. Enter the date that Data Begins as xx/xx/xx month/day/year.
11. Enter the date that Data Ends as xx/xx/xx month/day/year.
12. Mark chosen standard reports. Check the appropriate box(es).
13. Describe your request for non-standard data. Attach additional pages as needed.
14. Tell us how the data will be used. Check the appropriate box(es).
15. If other use, please summarize below. Attach additional pages as needed.
16. Are you requesting this data for someone else? Check the appropriate box(es).
17. If yes, enter the Requestor's Name.
18. If yes, enter the Requestor's Title.
19. If yes, enter the Requestor's Organization.
20. If yes, enter the Requestor's Telephone Number.
21. If yes, enter the Requestor's Organization Email Address.
22. If you are not a provider/advisory board/stakeholder, state your interest in EWC data. Attach additional pages as needed.
23. If you are not a provider/advisory board/stakeholder, enter your Mailing Address.
24. Enter an optional second line of Mailing Address.
25. If you are not a provider/advisory board/stakeholder, enter the City.
26. If you are not a provider/advisory board/stakeholder, enter the State.
27. If you are not a provider/advisory board/stakeholder, enter the Zip Code.
28. Review agreement Public Use of Data Agreement. Complete your signature indicating that you agree to abide by provisions regarding the use of California Cancer Detection and Treatment Branch (C.D.T.B.) data. (Electronic signature is acceptable.)
29. Enter your name.
30. Enter the date of your agreement.
31. Submit the completed Data Request Form and signed Agreement by email or fax:  
Print to PDF and email to EWCDMU@dhcs.ca.gov, listing "Data Request" in the subject line; or  
print, sign and fax to (916) 440-5631.
32. Please keep copies of all documents for reference.
33. Please respond promptly to program analysts; failure to respond within 30 days cancels the request.
34. EWC staff will respond to let you know your data request was received. If you do not receive a response within 7 days of requesting data, please contact the EWC Data Management Team at EWCDMU@dhcs.ca.gov or (916) 449-5300.