

WV Breast and Cervical Cancer Screening Program Client Enrollment Form

WVBCCSP Enrollment Facility: _____			
WVBCCSP #: _____		Enrollment Date (mm/dd/yyyy): ____/____/____	
Social Security #: _____		Date of Birth: ____/____/____	
Client Name (Last, First, MI): _____			
Client Address: _____			
City: _____		State: _____	
Day Phone: ____-____-____		Zip: _____	
		County: _____	
Evening/Alternate Phone: ____-____-____			
Insurance Status: <input type="checkbox"/> Uninsured : <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Underinsured : <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____ <input type="checkbox"/> Medicaid: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Medicare part B: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other Insurance: (specify): _____		Household Annual Income: \$ <input style="width: 100px;" type="text"/> Household Size: <input style="width: 100px;" type="text"/>	
Referral to Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Date referral to insurance (mm/dd/yyyy): ____/____/____		Income Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Demographic Update <input type="checkbox"/> Provider Location Change <input type="checkbox"/> WISEWOMAN Enrollment <input type="checkbox"/> Patient Navigation ONLY Enrollment			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Race: (choose up to 5) <input type="checkbox"/> Black or African American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
How did you hear about our Program? <input type="checkbox"/> Newspaper/ Radio/ TV <input type="checkbox"/> Patient in WVBCCSP <input type="checkbox"/> WVDOH <input type="checkbox"/> Friend/Relative/Word of Mouth <input type="checkbox"/> Medical Provider <input type="checkbox"/> Health Fair <input type="checkbox"/> Flyer/Poster/Brochure <input type="checkbox"/> Social Media (Facebook, Instagram etc.) <input type="checkbox"/> Internet (Website, search engine etc.) <input type="checkbox"/> Other: _____		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ Is interpreter required at the appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Consent for Release of Information and Statement of Confidentiality			
<p>I consent to the gathering, use, and disclosure of my information by the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP)/ WISEWOMAN. This information is needed for the purpose of providing benefits or services (including patient navigation), obtaining payment for my benefits or services, and to conduct normal business operations. By agreeing to take part in the WVBCCSP/WISEWOMAN, I give permission to any and all of my healthcare providers, clinics and/or hospitals to provide all information concerning Pap tests, breast exams, mammograms, lab work, and any other related care to the WVBCCSP/WISEWOMAN.</p> <p>Information given to WVBCCSP/WISEWOMAN will be confidential, which means information will be used to meet the purpose of the WVBCCSP/ WISEWOMAN and any published reports will not identify me by name. I understand that notifying me of test results is a very important part of the WVBCCSP/ WISEWOMAN, and that all available resources may be used to notify me if I have an abnormal test result.</p> <p>I agree to have a Pap test, breast exam, mammogram, patient navigation services, and lab work as recommended and I will participate in diagnostic tests (Program funded) and lifestyle interventions determined necessary. I give my consent for the WVBCCSP/WISEWOMAN and the West Virginia Medicaid program to coordinate my care and provide case management services as needed.</p> <p>I understand that knowingly providing false information may result in criminal, civil, or administrative action.</p>			
I, _____, swear that the information given on this form is true and correct.			
Signature: _____		Date Signed (mm/dd/yyyy): ____/____/____	
Staff signature: _____		Date Signed (mm/dd/yyyy): ____/____/____	
I understand that my participation in the WVBCCSP/WISEWOMAN is voluntary and that I may drop out and withdraw my consent to release information at any time. I have received a copy of the privacy policy.			