For LCC Use only		
Client Name (Last, First, MI)		Chart#:_____
Enrollment Site:		(Re-)Enrollment/ Date: _____

Idaho Women's Health Check Enrollment Form

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

WHC Client Demographics

Last Name: | First Name: | MI: | Date of Birth:

Former Last Name (If applicable): | SSN:

Street Address: | City: | State: | Zip code: | County of Residence:

Mailing Address: (if not the same as above) | City: | State: | Zip code:

E-mail Address: | Preferred Phone:

What Race do you consider yourself? (Check all that apply)
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Pacific Islander or Native Hawaiian
- ☐ American Indian or Alaska Native
- ☐ Unknown

What Ethnicity do you consider yourself? (Check one)
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

Additional Information

Have you used tobacco in the last 30 days? ☐ Yes ☐ No

If yes what kind (choose all that apply):
- ☐ Cigarettes
- ☐ Electronic Devices (vapes, e-cigs)
- ☐ Chewing Tobacco

Would you like information on free resources to help you quit?
- ☐ Yes
- ☐ No

In what language do you prefer to receive medical information?
- ☐ English
- ☐ Spanish
- ☐ Other: _____

What prompted this visit?
- ☐ Doctor referral or recommendation
- ☐ Referred by friend/relative
- ☐ Community event/health fair
- ☐ Media or newspaper advertisement
- ☐ Appointment reminder (mail, phone, e-mail)
- ☐ Other:_____

Emergency Contact (someone we may contact in case we are unable reach you):

Name: _____ Phone Number: _____

WHC Client Eligibility

Are you a U.S. Citizen? ☐ Yes ☐ No Place of Birth (State or Country):_____

If No, are you a Permanent Resident? ☐ Yes ☐ No Alien ID#: _____ (required) Issue Date: _____ (required)

Do you currently have health insurance? ☐ Yes ☐ No

If Yes, type of insurance
- ☐ Private, Name of company: _____
- ☐ Medicaid
- ☐ Medicare - Part A Only

What is your household size? _____

Number of children in household under 19: _____

Is a spouse currently living with you? ☐ Yes ☐ No

What is your total household income before taxes (gross)?

Monthly: _____ Annual:_____

PLEASE CHECK ALL BOXES, THEN SIGN AND DATE. Knowingly providing false information may result in criminal, civil or administrative action.
- ☐ The information I have provided on this form is correct.
- ☐ I wish to start/continue receiving services through Idaho's Women's Health Check.
- ☐ I am a U.S. Citizen *(original birth certificate or documentation of citizenship will be requested should you need treatment)* OR I am a Legal Permanent Resident and have lived in the United States for at least 5 years *(Alien ID card will be required should you need treatment).*

CLIENT SIGNATURE:_____ **DATE**: _____

FOR STAFF USE ONLY WHC Eligibility Verification (to be completed by Enrollment Center Staff)

The client meets all WHC enrollment requirements:
- ☐ Citizen/eligible alien
- ☐ No insurance coverage
- ☐ Income (use current table)

Age:
- ☐ 50-64 (eligible for breast and cervical screening)
- ☐ 21-49 (eligible for cervical screening)
- ☐ 21-49 (***limited enrollment – client is symptomatic for cancer, complete and attach limited enrollment form***)

FOR STAFF USE ONLY WHC Tobacco Use Assessment Verification (to be completed by Enrollment Center Staff)

If client states current tobacco user:

Was client referred to cessation service?
- ☐ Yes
- ☐ No
- ☐ Not Interested

If Yes, What type of referral? *Check all that apply*
- ☐ Quitline/Quitnet
- ☐ Health Department Cessation Class
- ☐ Community Cessation Service (describe): _____

Other (describe):_____

Eligibility verified by: _____ Date: _____

For LCC Use only		
Client Name (Last, First, MI)		Chart#:_____
Enrollment Site:		(Re-)Enrollment/ Date: _____

Program Consent and Information Release

Women's Health Check involves a cooperative effort between clinics, doctors, program evaluators, mammography facilities, laboratories, the Idaho Department of Health & Welfare, and the Centers for Disease Control and Prevention (CDC). The purpose of this program is to encourage screening for breast and cervical cancer for women who are U.S. citizens or eligible, low income non-citizens who have no other way to pay for screening tests (no private insurance, Medicare or Medicaid coverage to pay for these tests) The purpose of the screening is to prevent cancer or detect cancer at its earliest state so that it can be successfully treated. Screening for cervical cancer involves a pelvic examination and a Pap test. If needed, diagnostic tests may be available at no cost to you. Should you need treatment for cancer, you may qualify for treatment through the Breast and Cervical Cancer Medicaid Program.

I understand that (initial each statement below)...

_____ My signature certifies that the information on this application is true and correct; and I have read and understand the program description (above) of the Idaho Women's Health Check Program (WHC), understand that I am eligible for the program, and hereby consent to receive the health services as indicated above.

_____ A healthcare provider may ask for diagnostic tests that are not covered by Women's Health Check. If additional tests are ordered, I understand that I will make arrangements for payment with the healthcare provider for the tests or services not covered by Women's Health Check.

_____ By agreeing to take part in this program, I give permission to any and all of my doctors, clinics, mammography facilities, and/or hospitals to provide all information concerning my PAP tests, breast exams, mammograms and any related diagnostic and treatment procedures to the WHC program. Case managers employed by the program may contact me for purpose of gathering information to help me access important tests and exams for adequate follow-up of abnormal test results.

_____ Any information I give to WHC and participating providers is confidential. This means that WHC will not disclose or share my information, except for the minimum necessary to administer the Program described above. Reports, which result from this Program, will not use my name or any other identifying information.

_____ By signing this form, I am stating that I agree to, and understand, the terms of the program described above. I am also stating that the information I provided on the Enrollment Form is true. I understand that my participation in this Program is voluntary, and that I can drop out of the Program at any time.

_____ If I should be diagnosed with cancer or pre-cancerous conditions, I may qualify for treatment through the BCC Medicaid program and agree to release my information to Medicaid to determine if I am eligible for treatment.

_____ Women's Health Check routinely follows up with participants to learn about their experiences with the program. By signing this form, I am stating that I give my permission to be contacted by a program evaluator for the opportunity to participate in a follow-up survey.

_____ I have been offered the opportunity to read the Idaho Department of Health and Welfare's Notice of Privacy Practices (also available at www.healthandwelfare.idaho.gov).

☐Yes ☐No I would like Women's Health Check to send me a copy of the Idaho Department of Health and Welfare's Notice of Privacy Practices.

_____ _____ _____

Patient Signature Print Name Date

Enrollment Center Staff: Make a copy of both sides of this document and provide to patient for their records.