CERVICAL EXPANSION 21-39 YEARS OLD
WHC ENROLLMENT FORM FY21

WOMEN'S HEALTH CONNECTION (WHC) IN PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK (AHN)

APPLICANT ENROLLMENT INFORMATION

SSN:	DOB:	Age:	Birth place:
Last name:	First name:	Middle initial:	Maiden name:
Street address:	City:	State:	Zip:
Home phone:	Work phone:	Cell phone:	
Email:	Occupation:	Industry:	

Highest grade completed: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16+

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Eskimo ☐ Native Hawaiian ☐ Pacific Islander ☐ Other:

How did you hear about our program? ☐ Doctor ☐ Family/ Friend ☐ Radio/ TV ☐ Self ☐ Health Fair ☐ AHN ☐ Other:

Hispanic: ☐ Yes ☐ No

What is your primary language? ☐ English ☐ Spanish ☐ Other

APPLICANT ELIGIBILITY INFORMATION

Do you have medical insurance? ☐ Yes ☐ No If yes, list name and coverage:

Do you have Medicare Part B? ☐ Yes ☐ No Do you have Medicaid for yourself ? ☐ Yes ☐ No

How many people are in your household? What is your household income before taxes? Monthly: $ Yearly: $

APPLICANT MEDICAL HISTORY INFORMATION

Cervical History

Have you ever had a Pap test? ☐ Yes ☐ No Date of last Pap test (MM/DD/YY):

Date of last menstrual period (MM/DD/YY): Age menses started:

Have you had a hysterectomy? ☐ Yes ☐ No If yes, was the hysterectomy due to cervical cancer? ☐ Yes ☐ No

Are you on any hormone replacement therapy? ☐ Yes ☐ No

General History

What is your current height? What is your current weight? Are you physically active? ☐ Yes ☐ No

What is your smoking status? ☐ Never ☐ Current ☐ Former Are you exposed to secondhand smoke? ☐ Yes ☐ No

If you are over 50 years of age, have you ever been screened for colorectal cancer? ☐ Yes ☐ No

Have you been diagnosed with any of the following illnesses?

☐ Diabetes | Gestational Diabetes | High Blood Pressure | High Cholesterol | ☐ Stroke | ☐ Cancer | Please list cancer type:

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FOR OFFICE USE ONLY

WHC Member ID:	Clinic Name:	Date eligible (MM/DD/YY):

If the paient is a current smoker and was referred to 1-800-QUIT-NOW, indicate the date of referral (MM/DD/YY):

Comments:

APPLICANT ENROLLMENT INFORMATION

You are completing this form based on your presumptive eligibility for the WHC program. If you are referred to seek coverage through Medicaid or the health exchange marketplace, the WHC program will keep your information and track your insurance status to ensure you receive timely breast and cervical cancer screening. You may receive health promotion and screening reminders from the WHC program.

Should you be determined eligible for this program, you have the following rights and responsibilities:

Participant rights:

If you meet WHC's eligibility criteria (age, income, and insurance status), you may be eligible to receive a clinic/doctor visit, pelvic exam, and Pap smear at no cost. Ask your health care provider to tell you which specific services will be paid for by the WHC and how often you may receive them. Your clinic/doctor will let you know when you are due to return for your next Pap test and/or mammogram. Services provided to you that do not follow the WHC's schedule of services may become your financial responsibility.

If you have an abnormal screening test result, the clinic/doctor will work with WHC to help you obtain further diagnostic tests. The WHC does not pay for treatment but will assist you with the referral for treatment. Your health care provider at the clinic or your doctor can tell you which specific services WHC can pay for and those that are not covered.

If any abnormal results are found, case management services may be provided through WHC in order to ensure timely and appropriate diagnostic and treatment services.

You are encouraged to contact the WHC program at any time if you would like to provide feedback. If you receive questionnaires from the WHC program, please take the time to complete and return them.

Participant responsibilities:

Sign the Client Refusal Form if you wish to refuse procedures/treatment recommended by your doctor.

Update your contact information as it changes so the WHC may contact you by mail, email, phone or text message with appointment reminders, health and scheduled service information.

Provide consent for the release of medical information from your doctor, clinic, laboratory, radiology unit and/or hospital to WHC. Identifying information including name, address, social security number, and/or other identifying information will only be used by this program. It may be used to let you know if you need follow up exams. Other information may be used for studies done by WHC to learn more about women's health. Any such studies will not use any name or other identifying information.

Follow up with your clinic/doctor if you receive abnormal results, and participate in additional diagnostic procedures until a final diagnosis is reached.

WHC would like to send text messages to you on your provided cell phone number. Please note text message charges from your cell phone provider may apply.

☐ Yes, I would like to receive text messages from WHC. ☐ No, I do not wish to receive text messages from WHC.

I understand that knowingly providing false information could jeopardize my enrollment in the program. I have read and understood the explanation about WHC. My signature verifies my consent to participate in the program, and that I meet the eligibility information. I understand that my participation in the program is voluntary, and I may drop out of the program and withdraw my consent at any time.

Signature of Applicant:	Date (MM/DD/YY):

Provide contact information for a friend or family member that WHC may contact in case you can not be reached.

Name:	Phone:

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1-844-469-4934 | accesstohealthcare.org
4001 S. Virginia Street, Suite F | Reno, NV 89502

ANNUAL SCREENING VISIT FORM

Women's Health Connection (WHC) in Partnership with Access to Healthcare Network

PELVIC EXAM FINDINGS

Was a high risk cervical assessment preformed at this appointment?	☐ Yes	☐ No	
☐ Average risk			
☐ High risk			
☐ Unknown risk			
Has the patient had a hysterectomy?	☐ Yes	☐ No	If yes, is the cervix present? ☐ Yes ☐ No
Was the hysterectomy due to CIN or invasive cervical cancer?	☐ Yes	☐ No	
☐ Normal			☐ Abnormal, suspicious for cervical cancer - **must be referred to specialist**
☐ Abnormal, not suspicious for cervical cancer (explain in notes)			**Specialist**
☐ Not performed (explain in notes)			☐ Cervical Polyp
☐ Not indicated or not needed			
☐ Refused			☐ Patient is pregnant EDC (MM/DD/YY):

REASON FOR PAP/HPV TEST

Previous Pap test?	☐ Yes	☐ No	☐ Unknown	Date (MM/DD/YY):
Result:				
☐ Routine screening Co-test - Pap and HPV test (every 5 years)				☐ Primary HPV screening only
☐ Routine screening Pap test (every 3 years)				☐ Reflex HPV testing (HPV test as a F/U to pap test)
☐ Pap after primary HPV+				☐ Patient under surveillance for a previous abnormal test
☐ Co-test/Pap done outside WHC, patient referred for diagnostic services only				Referral date (MM/DD/YY):
Test result:				
☐ No Pap test performed - test not due				
☐ No HPV test performed - test not due				
☐ Refused				
☐ Not ordered (explain in notes)				
Notes:				

PLEASE FAX ALL <u>ABNORMAL</u> RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT <u>775-284-1918</u>

Clinician's signature:	Date of service (MM/DD/YY):

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received (MM/DD/YY):	Date entered (MM/DD/YY):
CaST ID#:	

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