WHC ENROLLMENT FORM FY22

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

APPLICANT ENROLLMENT INFORMATION

SSN:	DOB (MM/DD/YY):	Age:	Birth place:
Last Name:	First:	Middle Initial:	Maiden Name:
Street address:	City:	State:	Zip:
Home ph [ex. (111) 111-1111]:	Work ph [ex. (111) 111-1111]:		
Cell ph [ex. (111) 111-1111]:	Occupation:	Industry:	

Highest grade completed: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15+

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

Hispanic: ☐ Yes ☐ No

Preferred language: ☐ English ☐ Spanish ☐ Other:

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

How did you hear about our program? ☐ Doctor ☐ Radio/TV ☐ Family/friend ☐ Self ☐ Health fair ☐ AHN ☐ 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

Breast History

Are you experiencing breast symptoms? ☐ Yes ☐ No

Describe:

Do you have breast implants? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

Date of last mammogram (MM/DD/YY):

History of breast cancer in family?

☐ Self ☐ Mother ☐ Daughter ☐ Sister ☐ None ☐ Unknown

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 hysterectomy due to cervical cancer? ☐ Yes ☐ No

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

General History

How tall are you?	Feet:	Inches:	What is your weight?	Are you physically active? ☐ Yes	☐ No
Smoking status (please check one): ☐ Never ☐ Current ☐ Former	Date quit (MM/DD/YY):				
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 these diseases? (check all that apply) ☐ Diabetes ☐ Gestational diabetes ☐ High blood pressure ☐ High cholesterol ☐ Stroke ☐ Cancer Type of cancer:

WHC ENROLLMENT FORM FY22

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

FOR OFFICE USE ONLY

WHC member ID:	Clinic name:	Date eligible (MM/DD/YY):

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

Comments:

APPLICANT INFORMED CONSENT AND RELEASE OF MEDICAL INFORMATION

You are completing this form based on your presumptive eligibility for the WHC program. If you are referred to seek insurance 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:
1. If you meet WHC's eligibility criteria (age, income and insurance status), you may be eligible to receive a clinic/doctor visit, Pap smear, and clinical breast exam at no cost. Beginning at age 50 years, you may become eligible for a screening mammogram at no cost. Ask your Healthcare Provider to tell you which specific services will be paid by 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.
2. If you have an abnormal screening test result, the clinic/doctor will work with WHC to help you obtain further diagnostic tests. 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 the WHC can pay for and those that are not covered.
3. Case management services through WHC if any abnormal results are found, in order to receive timely and appropriate diagnostic and treatment services;
4. You are encouraged to contact the WHC program at any time. You may also receive questionnaires from the WHC program. Please take the time to complete and return client questionnaires.

Participant responsibilities:
1. You must sign the *Client Refusal Form* to refuse procedures/treatment recommended by your physician.
2. You must update contact information as it changes so WHC may send mail, e-mail, phone, or text message screening appointment reminders, health and scheduled service information.
3. You must provide consent for the release of medical information from your doctor, clinic, laboratory, radiology unit and/or hospital to the WHC. Identifying information such as name, address, social security number, and/or other identifying information will only be used by this program. It may be used to inform you if follow up exams are needed. Other information may be used for studies done by WHC to learn more about women's health. These studies will not use any name or other identifying information.
4. You must follow up with clinic/doctor if there are abnormal results, and to participate in additional diagnostic procedures until a final diagnosis is reached.

Do you authorize WHC to send text message screening reminders to you on your provided cell phone number? Text message charges from your cell phone provider may apply.

☐ Yes, please text me. ☐ No, please do not text me.

I understand that knowingly providing false information could jeopardize my enrollment in the program. I have read and understand the explanation above about the 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):

Please provide contact information for a friend or family member that WHC may contact in case you cannot be reached.

Name:	Phone number:

This publication was supported by the Nevada State Division of Public and Behavioral Health (DPBH) through grant number 1 NU58DP006306-01-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the DPBH or CDC.

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