Enrollment Form for Women 40-64

Every Woman Matters

NEBRASKA OFFICE OF WOMEN'S HEALTH

DHHS NEBRASKA

WEB-Version October 2009

Please write clearly. Shaded boxes must be filled in on Pages 1 and 2 and page 2 must be signed. Fill in as much of the rest of the form as you can.

Call us if you have questions
(800) 532-2227

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352. The Nebraska Department of Health and Human Services provides language assistance at no cost to limited English proficient persons who seek our services.

First Name	Middle Initial	**Last Name**	Maiden Name

Birthdate / /	Age	Social Security #

Address	**City**	County	**State**	**Zip**

Home/Cell Phone *circle one* ( )	**Work Phone** ( )	How did you hear about Every Woman Matters? ☐ family/friend ☐ agency ☐ other ☐ doctor/clinic ☐ self-referral ☐ newspaper/radio/TV ☐ outreach worker

Contact person *in case we can't reach you*	Relationship	Phone-Home / Work / Cell *circle one* ( )

Address	City	State	Zip

What race or ethnicity are you?
- ☐ American Indian Tribe _____
- ☐ Black/African American
- ☐ Mexican American
- ☐ White
- ☐ Asian
- ☐ Pacific Islander
- ☐ Other _____

Are you of Hispanic/Latina origin?
☐ Yes ☐ No

Country of origin _____

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

Highest grade in school you completed: *circle one* **0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+**

Have you ever had these exams in the past? *If you do not know exact date, give your best guess.*

Pap test ☐ No ☐ Yes Date last exam ___/___/___ Results: ☐ Normal ☐ Abnormal
What did your doctor say about your exam? _____

Mammogram ☐ No ☐ Yes Date last exam ___/___/___ Results: ☐ Normal ☐ Abnormal
breast x-ray
What did your doctor say about your exam? _____

Has your mother, sister or daughter ever had breast cancer?	☐ No	☐ Yes	☐ Don't Know
Have you ever had breast cancer?	☐ No	☐ Yes	☐ Don't Know
Have you ever had a hysterectomy *(removal of the uterus)*?	☐ No	☐ Yes	☐ Don't Know
If you have had a hysterectomy, was it to take care of cancer?	☐ No	☐ Yes	☐ Don't Know

I will be required to show proof that my income is within the EWM income guidelines when I am contacted by EWM program staff. If I am found to be over the income guidelines, I will be responsible for my bills.

What is your household income before taxes? **Yearly Income: $**	**How many people live on this income?**

Do you have:
- ☐ **Medicare Part A and B**
- ☐ **Medicare Part A only**
- ☐ **Medicaid (full coverage for self)**
- ☐ **None/No Coverage**
- ☐ **Private Insurance with or without Medicaid Supplement *(please list)***

_____

Is your insurance an HMO? ☐ **Yes** ☐ **No** *An HMO is a health maintenance organization.*

If you have Medicaid for yourself or your insurance is an HMO, you may not enroll in Every Woman Matters.

MUST READ AND SIGN BACK ☞☞☞☞

Mailing Address: Every Woman Matters-301 Centennial Mall South, P.O. Box 94817-Lincoln, NE 68509-4817

Informed Consent and Release of Medical Information

■ Read this page. Sign it to show that you know what it means and agree to it.

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■ **You must fill out and sign this page to be a part of Every Woman Matters Program**.

- I want to be a part of the Every Woman Matters (EWM) Program. I know I:
  - Must be between 40 and 64 years of age to receive screening services
  - Cannot be over income guidelines
  - Cannot have Medicaid
  - Cannot have Medicare
  - Cannot be a member of a Health Maintenance Organization (HMO)
- I know that I can tell EWM if I do not wish to be a part of this program anymore.
- I know that if I am 40-64 years of age I am eligible for full screening services under the EWM Program. I will receive a client booklet in the mail as soon as the EWM Office has my enrollment form. I will refer to my client booklet for more detailed information about the program.
- I know that if I am 40-64 years of age, I may receive breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon program guidelines. I have talked with my healthcare provider about the screening test(s) and understand possible side effects or discomforts.
- I may be given information to learn how to change my diet, get more exercise, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my healthcare provider about any related concerns or questions.
- I have talked with my healthcare provider about how I am going to pay for any tests or services that are not paid by EWM.
- I know that if I move without giving my mailing address to EWM, I will not get reminders about screenings. I accept responsibility for following through on any advice my healthcare provider may give me.
- My healthcare provider, laboratory, clinic, radiology unit, and/or hospital can give the results of my breast and cervical cancer screening exams, heart disease and diabetes screening exams, follow up exams, and/or treatment to EWM.
- To assist me in making the best healthcare decisions, EWM may share clinical and other healthcare information including lab results and health history with my healthcare providers.
- My name, address, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM and/or The Centers for Disease Prevention and Control (CDC) for use by outside researchers to learn more about women's health. These studies will not use my name or other personal information.

Every Woman Matters cannot pay for your services unless one of the 2 boxes below is checked.
ONE of the boxes below MUST be checked:

- For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States.

OR

☐ I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: _____, and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

_____

Please Print Name (first, middle, last) Client Signature

_____

Date of Signature/Enrollment Client Date of Birth

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services. #U58/DP000811, #U58/DP001421 and #1U58/DP002043-01