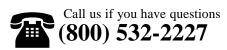
WEB-Version October 2009





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.



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.

NEBRASKA	N E B R A S K A proficient persons who seek our services.							
First Name	Middle Initial	L	ast Name			Maio	den Nam	e
Birthdate	Age			Socia	al Security #	<i>‡</i>		
Address			City		County		State	Zip
Home/Cell Phone () Work Phone ()			How did you hear about Every Woman Matters? ☐ other ☐ family/friend ☐ agency ☐ newspaper/radio/TV ☐ doctor/clinic ☐ self-referral ☐ outreach worker					
Contact person in case we	can't reach y	ои	Relationship		Phone-Ho	me /	Work / 0	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 ☐ Other ☐ Various of Hispanic/Latina origin? ☐ Yes ☐ No Country of origin ☐ What is your primary language? ☐ English ☐ Spanish ☐ Vietnamese☐ Other							n?	
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 What did your doctor say about your exam?								
Have you ever had breast cancer? Have you ever had a hysterectomy (removal of the uterus)? If you have had a hysterectomy, was it to take care of cancer? No Yes Don't Kno If you have had a hysterectomy, was it to take care of cancer? No Yes Don't Kno I will be required to show proof that my income is within the EWM income guidelines when I am contacted								Don't Know <u>Don't Know</u> ontacted
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? How many people live on this income?								
Yearly 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?								

Informed Consent and Release of Medical Information

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

 Version: October 2009
- 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 4-11 I am a citizen of the United States. OR	4, I attest as follows:					
I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows:							
	Please Print Name (first, middle, last)	Client Signature					
	Date of Signature/Enrollment	Client Date of Birth					