Women's Wellness Connection

CLIENT PROFILE TOOL

Colorado Department of Public Health and Environment

Women's Wellness Connection
Prevention Services Division

AGENCY #	CHART #	eCaST ID
ENROLLMENT/RE-ENROLMENT DATE	☐ I HAVE VERIFIED THIS PATIENT'S LAWFUL PRESENCE DOCUMENT IS CURRENT.	

TOBACCO SCREENING

☐ Screened Positive., agency faxed referral
☐ Screened Positive., client declined referral
☐ Screened Negative
☐ Client was not screened

PATIENT INSTRUCTIONS: Please fill in each part below. *Information is required for enrollment into the Women's Wellness Connection program.

IDENTIFICATION

LAST NAME*	FIRST NAME*	MIDDLE NAME*	MAIDEN NAME*

LAST 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER*	DATE OF BIRTH*	AGE*

WHAT ETHNICTY ARE YOU? CHOOSE ONE BELOW.*

☐ I am Latina and/or Hispanic.
☐ I am not Latina or Hispanic

WHAT RACE(S) ARE YOU? CHECK ALL THAT ARE TRUE.*

☐ Black/African American
☐ White
☐ American Indian (Tribe:_____)
☐ Asian
☐ Alaska Native
☐ Aleutian Islander
☐ Native Hawaiian
☐ I am not sure if I am Latina or Hispanic.
☐ Pacific Islander
☐ I am not sure
☐ Other: _____

ENROLLMENT

DO YOU HAVE PRIVATE INSURANCE OR MEDICAID?*

☐ Yes, I have Medicaid.
☐ Yes, I have private insurance.
Check below if any are true.
☐ But I have a high deductible.
☐ But does not cover cancer
☐ No, I do not have private insurance or Medicaid

DO YOU HAVE MEDICARE?*

☐ Yes, I have part A only.
☐ Yes, I have parts A and B.
☐ No, I do not have Medicare.

To the best of my knowledge, the GROSS MONTHLY (before taxes) income for my household is:*	Number of people living on this income including myself (this may include people not living in you house):*

CONTACT

HOW DID YOU HEAR ABOUT THE WOMEN'S WELLNESS CONNCECTION FREE BREAST AND CERVICAL SCREENING EXAMS?

☐ Brochure / Poster
☐ Clinic Staff / Physician
☐ Friend / Family Member
☐ Health Fair
☐ Hotline (866-951-9355)
☐ Newspaper Ad
☐ Patient Navigator
☐ Radio Ad
☐ TV Ad
☐ Website
☐ American Cancer Society Representative
☐ Other

PLEASE PROVIDE THE FOLLOWING NUMBERS WHERE WE CAN REACH YOU:	Mailing Address:		
PLEASE PROVIDE THE FOLLOWING NUMBERS WHERE WE CAN REACH YOU:	Home Phone number	State*	Zip*
Work Phone number	County*		
Cell Phone number	Email Address		
Emergency Contact List a phone number and name for someone who could call you if your phone number changes in the future or in an emergency:			

Women's Wellness Connection

CONSENT FORM

Colorado Department of Public Health and Environment

Women's Wellness Connection
Prevention Services Division

AGENCY #	CHART #	eCaST ID

PATIENT INSTRUCTIONS: Please read this page carefully before signing below.

LAST NAME*	FIRST NAME*	MIDDLE NAME*	MAIDEN NAME*
LAST 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER*		DATE OF BIRTH*	AGE*

I understand that by enrolling in Women's Wellness Connection (WWC) I agree to what is written on this form:

- ☐ I understand that the Women's Wellness Connection (WWC) is a program run by the Colorado Department of Public Health and Environment.
- ☐ WWC is a breast and cervical cancer screening program. WWC does not cover the costs of care that are not associated with breast or cervical cancer screenings.
- ☐ WWC does not pay for some tests. WWC does not pay for ANY cancer treatment. I have talked to someone from this clinic about what choices I have and understand that I may have to pay for some tests and treatment that WWC does not cover.
- ☐ I do not have Medicaid, Medicare, or other health insurance that will pay for these tests or my health insurance has a high deductible or copay that I cannot afford. I understand that if I do have health insurance and it covers cancer treatment, I will not be eligible for the Breast and Cervical Cancer Medicaid Program if I am diagnosed with breast or cervical cancer through the program.
- ☐ WWC has rules about who may enroll in the program. All of the information I have given to the clinic is true as far as I know. If I tell the clinic something that is not true, I may not get these tests, I may have to pay for any tests done, and I may not be eligible for the Breast and Cervical Cancer Medicaid Program if I am diagnosed with breast or cervical cancer through the program.
- ☐ I understand that WWC will receive some of my breast and cervical health related information. This may include parts of my medical history, test results and insurance information. WWC is very careful to keep my information private.
- ☐ I understand that WWC looks at the breast and cervical health information of the women enrolled in the program to help improve the health of all women. They also look at demographic information.
- ☐ My doctor, clinic, hospital, laboratory, and mammography center may share my information with: _ (contract agency name) and WWC.
- ☐ I understand that I have the right to withdraw from the WWC program. If I no longer want to be in WWC, I will inform my healthcare provider in writing and I will be withdrawn from the program by WWC and my healthcare provider. I understand that any information shared prior to my withdrawal shall be kept by WWC.
- ☐ I understand that I may get letters in the mail from my doctor to remind me when it is time for me to go back to my clinic for tests or treatment.

SIGNATURE _______________ DATE _______________

NAME (PLEASE PRINT) _______________

COMMUNITY HEALTH SERVICES INC

Verification of Lawful Presence

AFFIDAVIT

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

___ I am a United States citizen, or

___ I am a Permanent Resident of the United States, or

___ I am lawfully present in the United States pursuant to Federal law.

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

_____ _____

Signature **Date**