WV Breast and Cervical Cancer Screening Program
Client Enrollment Form

WVBCCSP Enrollment Facility: _____

WVBCCSP #: _____ **Enrollment Date** (mm/dd/yyyy): _____ /_____ / _____

Social Security #: _____ -_____ -_____ **Date of Birth**: _____ /_____ / _____

Client Name (Last, First, MI): _____

Client Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Day Phone: (____) _____ **Evening/Alternate Phone:** (____) _____

Insurance Status:
Medicaid : ☐ Yes ☐ No
Medicare Part B : ☐ Yes ☐ No
Other insurance: (Specify insurance) :_____
Underinsured: ☐ Yes ☐ No
Uninsured: ☐ Yes ☐ No

Ref. to Insurance? ☐ Yes ☐ No
Date ref. to insurance (mm/dd/yyyy): _____/_____/_____

Income Eligible? ☐ Yes ☐ No
Household Annual Income: $
Household Size: **(include yourself, if married, your spouse and dependent children)**

☐ **Demographic Update** ☐ **Provider Location Change**

☐ **WISEWOMAN Enrollment** ☐ **Patient Navigation ONLY Enrollment**

Ethnicity: Are you of Spanish or Hispanic origin, such as Mexican American, Latin American, Puerto Rican, or Cuban? ☐ Yes ☐ No

Race(s): What race do you consider yourself? Choose up to 5.
☐ Black or African American ☐ White ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Unknown

Education:
☐ Less than High School ☐ Some High School ☐ High School Graduate ☐ GED ☐ Technical School ☐ Some College
☐ College Graduate

Marital Status:
☐ Never Married ☐ Married ☐ Divorced/Separated ☐ Partnered ☐ Widowed

Gender: ☐ Female ☐ Transgender male ☐ Transgender female

How did you hear about our Program?
☐ Newspaper/ Radio/ TV ☐ Patient in WVBCCSP ☐ DHHR
☐ Friend/Relative/word of Mouth ☐ Medical Provider ☐ Health Fair
☐ Flyer/Poster/Brochure ☐ Social Media (Facebook, Instagram etc.)

Primary Language: ☐ English ☐ Spanish
☐ Other: _____

Needed interpreter at the appointment? ☐ Yes ☐ No

Living with a disability? ☐ Yes ☐ No

Consent for Release of Information and Statement of Confidentiality

I consent to the gathering, use, and disclosure of my information by the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP)/WISEWOMAN. This information is needed for the purpose of providing benefits or services (including patient navigation), obtaining payment for my benefits or services, and to conduct normal business operations. By agreeing to take part in the WVBCCSP/WISEWOMAN, I give permission to any and all of my healthcare providers, clinics and/or hospitals to provide all information concerning Pap tests, breast exams, mammograms, lab work, and any other related care to the WVBCCSP/WISEWOMAN.

Information given to WVBCCSP/WISEWOMAN will be confidential, which means information will be used to meet the purpose of the WVBCCSP/WISEWOMAN and any published reports will not identify me by name. I understand that notifying me of test results is a very important part of the WVBCCSP/WISEWOMAN, and that all available resources may be used to notify me if I have an abnormal test result.

I agree to have a Pap test, breast exam, mammogram, patient navigation services, and lab work as recommended and I will participate in diagnostic tests (Program funded) and lifestyle interventions determined necessary. I give my consent for the WVBCCSP/WISEWOMAN and the West Virginia Medicaid program to coordinate my care and provide case management services as needed.

I understand that knowingly providing false information may result in criminal, civil, or administrative action.

I, _____, swear that the information given on this form is true and correct.

Signature: _____ Date Signed (mm/dd/yyyy): _____/_____/_____

Witness: _____ Date Signed (mm/dd/yyyy): _____/_____/_____

I understand that my participation in the WVBCCSP/WISEWOMAN is voluntary and that I may drop out and withdraw my consent to release information at any time. I have received a copy of the privacy policy.