*(For LCC Use)*
Client Name (Last, First, M.I.): _____ Chart #: _____
Enrollment Site: _____ Enrollment/Re-Enrollment Date: _____/_____/_____

(vers. 10.2008)

# Idaho Women's Health Check Enrollment Form

IDAHO DEPARTMENT OF HEALTH & WELFARE

## Client Eligibility *(Please verify prior to enrollment and screening. For Office Use Only)*

1. U.S. Citizen? ☐ Yes ☐ No
   If No - Alien ID? ☐ Yes ☐ No
2. Total number living in household (including yourself) _____
   Is a spouse currently living with you? ☐ Yes ☐ No
   Number of children under age 19 _____
3. Do you currently have health insurance? ☐ Yes ☐ No
   Does it cover mammograms and Pap tests? ☐ Yes ☐ No
   Does the amount of your deductible prevent you from getting a mammogram or Pap test? ☐ Yes ☐ No
   Type of health insurance:
   ☐ Private
   Name of Company: _____
   ☐ Medicaid
   ☐ Medicare—Part A Only
4. Total household income (gross) before taxes:
   $_____yearly or $_____monthly
5. Age: ☐ 50-64 (eligible for breast and cervical screening)
   ☐ 40-49 (eligible for cervical screening)
   ☐ 30+ * (limited enrollment—client symptomatic for cancer)
   **limited enrollment authorization form attached*

**This client meets all enrollment requirements.**
____ Citizen/eligible alien
*(alien must live in United States at least 5 continuous years)*
____ No insurance coverage
____ Income *(use current table)*
____ Age
**Eligibility verified by**: _____

## 1. Client Information *(required)*

**Last Name:**_____ **First:** _____ **Middle:** _____
**Maiden Name (*if applicable*):** _____ **Date of Birth:** _____/_____/_____
**U.S. Citizen?** ☐ **Yes** ☐ **No** **Place of Birth (State):** _____
**Social Security #:** _____-_____-_____ *OR* **Alien ID #:** _____ **Issue Date:** _____/_____ Mo./ Year
**Home Mailing Address:** _____
**City:** _____ **County:** _____ **State:** _____ **Zip:** _____
**Home/Cell Phone:** (_____) _____-_____ **Work Phone:** (_____) _____-_____

## 2. Ethnicity and Race *(all answers required)*

Ethnicity: *(check one)*
☐ Non-Hispanic
☐ Hispanic
☐ Unknown

What race do you consider yourself? *(check all that apply)*
☐ White
☐ Black or African American
☐ Asian
☐ Pacific Islander or Native Hawaiian
☐ American Indian or Alaska Native
☐ Unknown

What language do you prefer for medical information? *(check one)*
☐ English
☐ Spanish

## 3. Emergency Contact

Someone we may contact in case we cannot reach you:
First Name: _____
Last Name: _____
Phone: (_____) _____-_____

## 4. How did you hear about this program? *(check all that apply)*

☐ Health Care Provider
☐ Community Event/Health Fair
☐ Friend/Relative
☐ Health Department
☐ Radio
☐ Television
☐ Other _____
☐ American Cancer Society
☐ Church Bulletin
☐ Foodbank
☐ Newspaper
☐ Reminder Notice
☐ Web

*Please check all that apply. Knowingly providing false information may result in criminal, civil or administrative action.*

☐ The information I have provided on this form is correct.
☐ I wish to start/continue receiving services through Idaho's Women's Health Check.
☐ I am a U.S. Citizen. *(*Original birth certificate or documentation of citizenship will be required should you need treatment.)*
*OR* ☐ I have an Alien ID and have lived in the United States for at least 5 years. (Alien ID card will be required should you need treatment.)

**Client Signature**: _____ **Date:**_____/_____/_____