

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT

Read instructions on reverse prior to completing this form. Print clearly. Client information in this document is confidential under Wis. Stats 146.82

PERSONAL INFORMATION - Completed by Client

1. Last Name: 2. First Name: 3. Middle Initial: 4. Previous Last Name: 5. Street Address: 6. City: 7. State: 8. Zip: 9. County of Residence: 10. Native American Tribe: 11. Date of Birth: 12. Client Identification No.: 13. Social Security No.: 14. Day Telephone No.: 15. Other/Cell Phone No.: 16. Mailing Address: 17. City: 18. State: 19. Zip: 20. Race: 21. Ethnicity: 22. Emergency contact, not living with you: 23. Relationship: 24. Address: 25. City: 26. State: 27. Zip: 28. Contact Person's Day Telephone No.: 29. Other/Cell Phone No.:

INSURANCE INFORMATION - Completed by Client

30. Do you have Medicaid (including Family Planning Waiver)? 31. Do you have Medicare Part B? 32. Do you have health insurance? 33. Do you have disability health insurance?

HEALTH CARE PROVIDER INFORMATION - Completed by Client

34. Do you have a primary health care provider? 35. If Yes, Name of Provider: 36. Clinic Name: 37. Street Address: 38. City: 39. State: 40. Zip: 41. How did you hear about this program?

CLIENT PARTICIPATION AGREEMENT

I understand and agree to the following: the Wisconsin Well Woman Program (WWWP) will use the personally identifiable information only for program enrollment, program administration and case management. I give WWWP permission to release my medical information to the Local Coordinating Agency (LCA), other service providers, referral agencies and the State of Wisconsin. I understand that WWWP pays for preventive screening services, but does not pay for medical treatment services. I have seen the current program eligibility criteria and, to the best of my knowledge, my annual income does not exceed them. All of the information I have given is true and correct. I will inform the WWWP LCA if I move or if I no longer wish to participate. I understand the enrollment is valid for one (1) year from the date signed.

43. SIGNATURE - Applicant: 44. Date Signed: 45. SIGNATURE - Witness: 46. Date Signed:

Office Use Only

47. Enrollment Re-Enrollment Dis-Enrollment Date (mm/dd/yyyy): Deceased Date of death (mm/dd/yyyy): 48. Certifying Agency No.: 49. Certifying Agency Name: 50. Enrollment Start Date (mm/dd/yyyy): 51. Enrollment End Date (mm/dd/yyyy): 52. Age >= 35: 53. Income <= 250% of Federal Poverty Level: 54. Uninsured 55. Underinsured 56. Translation services needed: 57. Language: 58. Household size: 61. Meets Eligibility Requirements Eligibility Confirmed By: 62. Printed name: 63. Signature: