WOMEN'S HEALTH CONNECTION (WHC) ENROLLMENT FORM

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

APPLICANT PERSONAL INFORMATION

Last Name:	First Name:	M.I.	Maiden Name:
SSN:	DOB (mm/dd/yyyy):	Gender: ☐ Female ☐ Male	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			

APPLICANT CONTACT INFORMATION

Address:		Address 2:	
Zip Code:	State:	County:	City:
Email:		Receive information by email: ☐ Yes ☐ No	
Home Phone: ☐ Preferred Contact		Best Time to Call:	
Work Phone: ☐ Preferred Contact		Authorize WHC to send screening reminder texts to your cell phone? Msg & data rates may apply.	
Cell Phone: ☐ Preferred Contact		☐ Yes ☐ No	

APPLICANT DEMOGRAPHIC INFORMATION

Country of Birth:	Hispanic: ☐ Yes ☐ No
Preferred Language: ☐ English ☐ Spanish ☐ Other	Needs Translator: ☐ Yes ☐ No
Race: (check all that apply) ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Pacific Islander / Native Hawaiian ☐ Unknown	
Highest grade completed: ☐ <9th grade ☐ Some high school ☐ High school graduate or equivalent ☐ Some college or higher ☐ Don't know ☐ Don't want to answer	

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APPLICANT DEMOGRAPHIC INFORMATION (CONTINUED)

How did you hear about our program?

- ☐ Provider
- ☐ Postcard
- ☐ Social Media
- ☐ Friend / Relative
- ☐ BCCP Reminder
- ☐ Website
- ☐ Other
- ☐ Outreach Worker
- ☐ Radio
- ☐ Self
- ☐ TV
- ☐ Unknown

APPLICANT ELIGIBILITY INFORMATION

Do you have medical insurance? ☐ Yes ☐ No

If Yes, list name and coverage:

Do you have Medicare Part B? ☐ Yes ☐ No

Do you have Medicaid for yourself? ☐ Yes ☐ No

What is your household income before taxes?

Income Frequency:

Monthly Yearly

Number of people living on this income?

APPLICANT MEDICAL HISTORY INFORMATION

Breast History

Are you experiencing breast symptoms? ☐ Yes ☐ No

Describe:

Do you have breast implants? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

Date of last mammogram (mm/dd/yyyy):

History of breast cancer in the family?

☐ Self ☐ Mother ☐ Daughter ☐ Sister ☐ None ☐ Other

Cervical History

Have you ever had a Pap test? ☐ Yes ☐ No

Date of last Pap exam (mm/dd/yyyy):

Result:

Have you ever had an HPV test? ☐ Yes ☐ No

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Cervical History (Continued)		
Date of last menstrual period (mm/dd/yyyy):	Age menses started:	
Have you had a hysterectomy?	☐ Yes	☐ No
If yes, was the hysterectomy due to cervical cancer?	☐ Yes	☐ No
Are you on any hormone replacement therapy?	☐ Yes	☐ No

GENERAL HISTORY

The following questions are for statistical purposes only and will not affect eligibility:

How do you describe yourself? (Mark one answer)

- ☐ Male
- ☐ Female
- ☐ Transgender Man / Trans Male
- ☐ Transgender Woman / Trans Female
- ☐ Genderqueer / Gender Non-Conforming
- ☐ Different Identity (Please specify)
- ☐ Prefer not to disclose

Which of the following best represents your sexual orientation identity? (Mark one answer)

- ☐ Straight or heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Transgender
- ☐ Not Listed (Please specify)
- ☐ Prefer not to disclose

What sex were you assigned at birth, such as on your original birth certificate? (Mark one answer) ☐ Male ☐ Female

Smoking Status (Please check one): ☐ Never ☐ Current ☐ Former Date quit (mm/dd/yyyy):

Are you exposed to secondhand smoke? ☐ Yes ☐ No

FOR OFFICE USE ONLY

WHC Member ID:	Clinic Name:
Date Eligible (mm/dd/yyyy):	Date Received (mm/dd/yyyy):
If client is a current smoker and was referred to 1-800-QUIT-NOW, indicate date (mm/dd/yyyy):	
Comments:	

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APPLICANT INFORMED CONSENT AND RELEASE OF MEDICAL INFORMATION

You are completing this form based on your presumptive eligibility for the WHC program. If you are referred to seek insurance coverage through Medicaid or the health exchange marketplace, the WHC program will keep your information and track your insurance status to ensure you receive timely breast and cervical cancer screening. You may receive health promotion and screening reminders from the WHC program.

Should you be determined eligible for this program, you have the following rights and responsibilities:

Participant Rights:

1. If you meet WHC's eligibility criteria (age, income, and insurance status), you may be eligible to receive a clinic/doctor visit, Pap smear, and clinical breast exam at no cost. Beginning at age 40 years, you may become eligible for a screening mammogram at no cost. Ask your Healthcare Provider to tell you which specific services will be paid by WHC and how often you may receive them. Your clinic/doctor will let you know when you are due to return for your next Pap test and/or mammogram. Services provided to you that do not follow the WHC's schedule of services may become your financial responsibility.
2. If you have an abnormal screening test result, the clinic/doctor will work with WHC to help you obtain further diagnostic tests. WHC does not pay for treatment but will assist you with the referral for treatment. Your health care provider at the clinic or your doctor can tell you which specific services the WHC can pay for and those that are not covered.
3. You may receive case management services through WHC if any abnormal results are found in order to receive timely and appropriate diagnostic and treatment services.
4. You are encouraged to contact the WHC program at any time. You may also receive questionnaires from the WHC program. Please take the time to complete and return client questionnaires.

Participant Responsibilities:

1. You must sign the Client Refusal Form to refuse procedures/treatment recommended by your physician.
2. You must update contact information as it changes so WHC may send mail, e-mail, phone, or text message screening appointment reminders, health and scheduled service information.
3. You must provide consent for the release of medical information from your doctor, clinic, laboratory, radiology unit and/or hospital to the WHC. Identifying information such as name, address, social security number, and/or other identifying information will only be used by this program. It may be used to inform you if follow-up exams are needed. Other information may be used for studies done by WHC to learn more about women's health. These studies will not use any name or other identifying information.
4. You must follow up with clinic/doctor if there are abnormal results, and to participate in additional diagnostic procedures until a final diagnosis is reached.

I understand that knowingly providing false information could jeopardize my enrollment in the program. I have read and understand the explanation above about the WHC. My signature verifies my consent to participate in the program, and that I meet the eligibility information. I understand that my participation in the program is voluntary, and I may drop out of the program and withdraw my consent at any time.

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APPLICANT INFORMED CONSENT AND RELEASE OF MEDICAL INFORMATION	
Signature of applicant:	Date (mm/dd/yyyy):
Please provide the name and number of a friend or family member that a WHC Program team member may contact in case you cannot be reached.	
Name:	Phone Number:

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WOMEN'S HEALTH CONNECTION (WHC) OFFICE VISIT FORM

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

CLIENT INFORMATION

Last Name:	First Name:	DOB (mm/dd/yyyy):

CLINICAL BREAST EXAM (CBE) FINDINGS

Was a high-risk breast assessment performed at this appointment? ☐ Yes ☐ No

☐ Average risk ☐ High risk ☐ Unknown risk

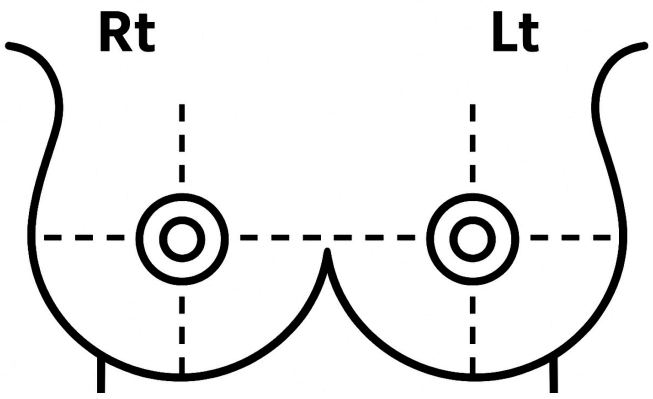
Does the patient have breast symptoms? ☐ Yes ☐ No

Does the patient have breast implants? ☐ Yes ☐ No

CBE Results

- ☐ Normal
- ☐ Benign (fibrocystic changes, diffuse lumpiness or nodularity)
- ☐ Discrete palpable mass – previously diagnosed as benign
- ☐ Not performed (explain in notes)
- ☐ Refused
- ☐ Confirmation of breast cancer diagnosis
- ☐ *Bloody / serous nipple discharge
- ☐ *Focal pain / tenderness
- ☐ *Discrete palpable mass – suspicious for cancer
- ☐ *Nipple / areolar scaliness
- ☐ *Skin dimpling / retraction

Please indicate abnormality and size on the diagram below.



***Diagnostic services (mammogram and / or ultrasound) must be completed first before referral to a specialist**

REASON FOR IMAGING (PLEASE REMIND PATIENT TO SCHEDULE APPOINTMENT WITHIN 60 DAYS)

Did patient have a previous screening mammogram? ☐ Yes ☐ No

Date (mm/dd/yyyy):	Location:

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REASON FOR IMAGING (CONTINUED)

- ☐ Routine screening mammogram **(only for patients age 40+)**
- ☐ Diagnostic mammogram and/or ultrasound **(only for patients age 40-49 with an abnormal CBE result)**
- ☐ Ultrasound **(only for patients age 40+ with an abnormal CBE result)**
- ☐ Magnetic Resonance Imaging (MRI) **(for high-risk women)**
- ☐ Imaging done outside WHC, client referred for diagnostic services only

Referral date (mm/dd/yyyy):	Imaging results:

Notes:

PELVIC EXAM FINDINGS

Was a high-risk cervical assessment performed at this appointment? ☐ Yes ☐ No

☐ Average risk ☐ High risk ☐ Unknown risk

Has the patient had a hysterectomy? ☐ Yes ☐ No

Was the hysterectomy due to Cervical Intraepithelial Neoplasia (CIN) or invasive cervical cancer? ☐ Yes ☐ No

If yes, is the cervix present? ☐ Yes ☐ No

Pelvic Exam Results

- ☐ Normal
- ☐ Not performed
- ☐ Refused
- ☐ Not indicated or needed
- ☐ Abnormal, not suspicious for cervical cancer (explain in notes)
- ☐ Abnormal, suspicious for cervical cancer (explain in notes) – must be referred to a specialist

Notes:

Specialist

- ☐ Cervical polyp
- ☐ Patient is pregnant

Estimated date of confinement (mm/dd/yyyy):

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REASON FOR PAP/HPV TEST				
Previous Pap test? ☐ Yes ☐ No ☐ Unknown				Date (mm/dd/yyyy):
Result:				
☐ Routine screening co-test – Pap / HPV test (every 5 years)			☐ Primary HPV screening only	
☐ Routine screening Pap test (every 3 years)			☐ Reflex HPV testing (HPV test as F/U to Pap test)	
☐ Pap after primary HPV+			☐ Patient under surveillance for a previous abnormal test	
☐ Co-test done outside WHC, patient referred for diagnostic services only				
Referral date (mm/dd/yyyy):				
Test result:				
☐ No Pap test performed – test not due			☐ Refused	
☐ No HPV test performed – test not due			☐ Not ordered (explain in notes)	
Notes:				
PLEASE FAX ALL ABNORMAL RESULTS TO A WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918				
Clinician's signature:			Date of service (mm/dd/yyyy):	
WHC OFFICE USE ONLY				
Date received (mm/dd/yyyy):	Date entered (mm/dd/yyyy):		Med-IT ID#:	

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