

Wisconsin Well Woman Program (WWWP) Enrollment

Print clearly. Client information in this document is confidential under Wis. Stat. § 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 code: _____
9. County of residence: _____
10. Native American tribe: _____
11. Date of birth (mm/dd/yy): _____
12. Client identification number: _____ - _____ - _____
13. Social Security number: _____ - _____ - _____
14. Phone number: _____
15. Other cell phone number: _____
16. Mailing address (if different from above): _____
17. City: _____ 18. State: _____ 19. ZIP: _____

20. Race (check all that apply):

☐ White

☐ Black or African American

☐ Asian

☐ Native Hawaiian or other Pacific Islander

☐ American Indian or Alaska native

☐ Unknown

21. Ethnicity:

☐ Hispanic or Latina

☐ Non-Hispanic

☐ Unknown

22. Emergency contact, not living with you: _____

23. Relationship: _____

24. Address: _____

25. City: _____ 26. State: _____ 27. ZIP: _____

28. Contact person's day phone number: (_____) _____

29. Other or cell phone number: (_____) _____

Insurance information – completed by client

30. Do you have Medicaid (including family planning waiver)? ☐ Yes ☐ No

31. Do you have Medicare Part B? ☐ Yes ☐ No

32. Do you have health insurance? ☐ Yes ☐ No

33. Do you have disability health insurance? ☐ Yes ☐ No

Health care provider information – completed by client34. Do you have a primary health care provider? ☐ Yes ☐ No

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?

☐ WWWP coordinator☐ Brochure or poster☐ Billboard☐ Relative or friend☐ Clinic or health care☐ Bus advertisement☐ Radio or TV☐ provider☐ Other☐ Newspaper☐ Fair**42. 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 only47. ☐ Enrollment ☐ Re-Enrollment ☐ Dis-Enrollment Date (mm/dd/yy): _____

48. Certifying agency number: _____ 49. Certifying agency name: _____

50. Enrollment start date (mm/dd/yy): _____

51. Enrollment end date (mm/dd/yy): _____

52. Age: ≥ 35 ☐ Yes ☐ No53. Income $\leq 250\%$ of federal poverty level ☐ Yes ☐ No54. ☐ Uninsured 55. ☐ Underinsured

(See insurance information above)

56. Translation services needed: ☐ Yes ☐ No 57. Language: _____

58. Household size: _____

59. ☐ Meets eligibility requirements

Eligibility confirmed by:

60. Printed name: _____

61. Signature: _____