WISEWOMAN Women's Health Income Form

Name: _____ DOB: _____ Age: _____

E-mail: _____ Day Phone:_____

Please complete this form if you are between the ages of 21-64. If you meet BOTH criteria for age, and income based on household size then you will be enrolled in the WISEWOMAN Women's Health program. See the list of services that are covered on the back side of this form.

Directions

1. Circle your household size. Household size includes all people who live on this income
2. Look at the corresponding monthly average of household income
3. Determine if your household income is above or below this number. Household income includes all money coming into your household, not including dividends.
4. Check box indicating if the monthly average in your household income is above or below the amount listed.

HOUSEHOLD SIZE	HOUSEHOLD INCOME: ESTIMATED MONTHLY AVERAGE	
1 ☐	$3,794	☐ BELOW Eligible for services
2 ☐	$5,133	
3 ☐	$6,473	
4 ☐	$7,813	
5 ☐	$9,152	☐ ABOVE Not eligible for services
6 ☐	$10,492	
7 ☐	$11,831	
8 ☐	$13,171	

Do you consider yourself to be Hispanic or Latina?

☐ Yes ☐ No

Please check all that apply:

☐ Alaska Native or American Indian ☐ White ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ African American ☐ Unknown

I have read and agree to all of the conditions outline on the reverse side of this form. All information that I have provided is correct to the best of my knowledge.

Signature: _____ Date: _____

How did you hear about our programs?

☐Brochure/Poster ☐ Clinic Staff/Physician ☐ Friend- Family Member ☐Mobile Mammogram Visit
☐Newspaper Ad ☐Social Media ☐ Mailing ☐Radio Ad ☐Re-enrollment ☐ Community Event ☐Other

Please check all that apply:

☐ No private insurance, Medicaid, or Medicare (You will be referred to Outreach & Enrollment)
☐ Insurance does not cover preventive care
☐ I cannot pay my deductible

Updated: 11/30/23

I understand that the SEARHC Women's Health programs (BCHP and WISEWOMAN) are grant-funded and can only provide screening for breast and cervical cancer, heart disease, and stroke.

I understand that a Women's Health program screening consists of the following:

- Ages: 21 - 64: An office visit, including a clinical breast exam, pelvic exam, and Pap smear
- Ages: 35 - 64: The above, plus cholesterol and glucose blood tests, height, weight, blood pressure, and a Health Risk Assessment.
- Ages: 40 - 64: The above, plus a mammogram.

I understand some specific follow-up diagnostic tests will be provided, if necessary, but the Women's Health programs cannot pay for complete diagnostic services or any treatment* or travel for treatment. If I need further testing, I agree to work with Women's Health staff for these services. Services covered by these grants are outlined in the Women's Health Covered Services cards.

I understand that if I am not a Native Beneficiary I will be billed for any services

other than those defined above.

I understand I may drop out of the Women's Health program at any time.

I understand that in order to participate in these programs, my medical record will be made available to the SEARHC Women's Health staff for payment, quality control, and follow-up. These records will be held strictly confidential.

I understand that limited information, without my name, will be shared with the grant funding agency (CDC) on a confidential and as-needed basis, for program monitoring only.

Signature: _____

*The State of Alaska Medicaid Program enables women who are enrolled in the SEARHC Women's Health program and found to be in need of treatment for either breast or cervical cancer, or cervical dysplasia, to apply for treatment costs.

For Office Use Only: Email completed form to **whenroll@searhc.org**

Verified by WW WH Staff : _____ Date: _____ Screening Site: _____

□ WW and WHG entered into Cerner □ WHG only entered into Cerner

□ AIF entered into Cerner □ Beginning and End Eligibility Date in Patient Demographic Notes

□ If uninsured, referral made to Outreach & Enrollment (outreach@searhc.org)

□Approved □ Denied

Updated: 11/30/23