SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

WISEWOMAN Women's Health

Income Form

Name: ______________________ DOB: __________ Age: ______

E-mail: ______________________ Phone: ______________

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

Directions:

1. Circle your household size. Household size includes all people who live on this income.
2. Review the corresponding household income amount.
3. Determine if your household income is above or below the income number that corresponds to your household size. Household income includes all money from all wage earners within your household, excluding Tribal or State dividends.
4. If your monthly income is below the corresponding amount listed, check the box below the table.

HOUSEHOLD SIZE	HOUSEHOLD INCOME: ESTIMATED MONTHLY AVERAGE
1	$3,919
2	$5,321
3	$6,723
4	$8,125
5	$9,527
6	$10,929
7	$12,331
8	$13,733

☐ My average monthly household income, based on household size, is below the amount listed. I qualify for the WISEWOMAN Women's Health program.

Do you consider yourself to be Hispanic or Latina?

☐ Yes ☐ No

Race. Please check all that apply:

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

Insurance. Please check all that apply:

☐ No private insurance, Medicaid, or Medicare (will be referred to Patient Health Benefits).
☐ Insurance does not cover preventive care.
☐ I am unable to pay the private insurance deductible.

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

Signature: ______________________ Date: ______________

Please turn over

How did you hear about our programs?

- ☐ Physician/Staff
- ☐ Mailing
- ☐ Re-enrollment
- ☐ WISEWOMAN Rep.
- ☐ Brochure/Poster
- ☐ Newspaper
- ☐ Friend/Family Member
- ☐ Radio
- ☐ Social Media
- ☐ Mobile Mammogram Visit
- ☐ Community Event
- ☐ Other: ________________

I understand that the WISEWOMAN Women's Health program is grant-funded and screening is limited to breast and cervical cancer, heart disease and stroke.

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

- Ages 21-29: Pap and HPV test in office visit and follow-up for breast and cervical diagnostic tests.
- Ages 30-39: The above, plus blood pressure check, hemoglobin A1c, cholesterol test, tobacco cessation support, health coaching sessions, access to community resources, 6-month follow up rescreening and annual cardiovascular health assessment.
- Ages 40-64: The above, plus screening mammogram.

I understand some specific follow-up diagnostic tests will be provided, if necessary, but the WISEWOMAN Women's Health program cannot pay for complete diagnostic services, treatment* or travel for treatment. If I need further testing, I agree to work with WISEWOMAN Women's Health program staff for these services.

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 unenroll from the WISEWOMAN Women's Health program at any time.

I understand that in order to participate in this program, my medical record will be made available to the WISEWOMAN Women's Health program 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, Centers for Disease Control and Prevention (CDC), on a confidential and as-needed basis, for program monitoring only.

Signature: ______________________________ Date: ________________

**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 WWWH Staff: ______________ Screening Site: ______________ Date: ________

- ☐ WWWH entered into patient Electronic Health record (EHR)
- ☐ Beginning and ending eligibility dates entered into EHR (Demographic Notes)
- ☐ If uninsured, referral made to Patient Health Benefits (outreach@searhc.org)
- ☐ Approved