



Women's Wellness Programs

21-39

Overview:

The Women's Wellness Program is a program that provides specialized services for women through the breast, cervical and cardiovascular disease screening process. These programs are provided by the Colorado Department of Public Health and Environment. One of the programs offered is a program for cervical care for women age **21-39**.

Women are eligible if they*:

- Are between 21 and 39 years of age
- Have family income at or below 250% of the Federal Poverty Level

Services that can be provided*:

- Cervical services

Enrollment: Women may enroll in the program by completing the program paperwork and scheduling an exam. Please ask an Enrollment Specialist or Customer Service Associate for assistance.

****Enrollment in programs or services provided are not guaranteed. Please fill out a packet and someone will be in contact with you regarding the program you are enrolled in.**

CLIENT PROFILE TOOL



(Internal use)

AGENCY #	CHART #	eCaST ID
ENROLLMENT/RE-ENROLLMENT DATE		

UNINSURED CLIENT: REFERRED FOR INSURANCE (mark all that apply)

Medicaid Other: _____
 Connect for Health Colorado Client not referred

PATIENT INSTRUCTIONS: Please fill in each part below. *Information is required for enrollment into the Women's Wellness Connection program.

IDENTIFICATION

LAST NAME*	FIRST NAME*	MIDDLE NAME*	MAIDEN NAME*
LAST 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER*		DATE OF BIRTH*	AGE*

WHAT ETHNICITY ARE YOU? CHOOSE ONE BELOW.*

I am Latina and/or Hispanic. I am not Latina or Hispanic. I am not sure if I am Latina or Hispanic.

WHAT RACE(S) ARE YOU? CHECK ALL THAT ARE TRUE.*

Black/African American Asian Pacific Islander
 White Alaska Native I am not sure
 American Indian (Tribe: _____) Aleutian Islander Other: _____
 Native Hawaiian

ELIGIBILITY

DO YOU HAVE PRIVATE INSURANCE OR MEDICAID?*	DO YOU HAVE MEDICARE?*
<input type="checkbox"/> Yes, I have Medicaid. <input type="checkbox"/> Yes, I have private insurance. Check below if any are true. <input type="checkbox"/> But I have a high deductible. <input type="checkbox"/> But does not cover cancer <input type="checkbox"/> No, I do not have private insurance or Medicaid.	<input type="checkbox"/> Yes, I have part A only. <input type="checkbox"/> Yes, I have parts A and B. <input type="checkbox"/> No, I do not have Medicare.

To the best of my knowledge, the GROSS MONTHLY (before taxes) income for my household is:*	Number of people living on this income including myself (this may include people not living in you house):*
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CONTACT

HOW DID YOU HEAR ABOUT THE WOMEN'S WELLNESS CONNECTION FREE BREAST AND CERVICAL SCREENING EXAMS?

Brochure / Poster
 Newspaper Ad
 Radio Ad
 Targeted Community Outreach (TCO)
 Other

PLEASE PROVIDE THE FOLLOWING ADDRESS WHERE WE CAN REACH YOU:	Emergency Contact List a phone number and name for someone who could call you if your phone number changes in the future or in an emergency:
Mailing Address:	
City* State* Zip*	
County*	
Email Address	

CONSENT FORM



AGENCY OR SITE #	eCaST ID	DATE OF BIRTH	AGE
LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME

To the best of my knowledge, the GROSS MONTHLY (before taxes) income for my household is: _____. The number of people living on this income including myself (this may include people not living in your house) is: _____.

CLIENT INSTRUCTIONS: Please read this page carefully before signing at the bottom. By signing this form, you are consenting to enrollment for ALL three programs listed below, if offered by this clinic and if you are eligible. You will remain enrolled as long as you meet eligibility requirements and do not request to be withdrawn.

I am enrolling in Health Navigation through the Women's Wellness Connection (WWC) and I understand the following: Health Navigation will help me move through the healthcare system to achieve the best possible breast and cervical health results. This program provides Health Navigation breast and cervical appointments depending on my age. Health Navigation does not pay for tests or clinic visits. This program may include help with:

- Learning where to sign up for health insurance
- Education about health screening tests
- Understanding test results
- Scheduling appointments

I am enrolling in Clinical Services through the Women's Wellness Connection (WWC) and I understand the following: Clinical Services pays for testing in order to screen and diagnose breast and cervical cancer depending on my age. The program does not pay for tests and care that are not related to finding breast or cervical cancer. I have talked to someone at this clinic and understand the choices available to me if cancer is diagnosed. As part of Clinical Services, I understand that I cannot have Medicaid, Medicare, or other health insurance that will pay for these tests or my health insurance has a high deductible or co-pay that I cannot afford.

I am enrolling in the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program and I understand the following: The WISEWOMAN program pays for screening for cardiovascular disease risk factors (assessment of body mass index, blood pressure, cholesterol, and glucose), risk reduction counseling, medical follow-up (if required) and healthy behavior support options, for which my insurance does not pay, in an effort to prevent cardiovascular disease.

I also understand the following:

- WWC & WISEWOMAN will gather my breast, cervical and cardiovascular health information. This may include: name, age, income, legal presence, insurance status, test results, family and personal medical history. Information obtained by the program is used to find new ways to improve the health of all women.
- I may get communication, including phone calls, letters in the mail or emails to remind me when it is time to go back to my clinic for tests or treatment.
- WWC & WISEWOMAN programs are run by the Colorado Department of Public Health and Environment (CDPHE).
- My health information can be shared for care and treatment purposes for this program with my doctor, clinic, hospital or laboratory, and my doctor, clinic, hospital or laboratory may use and disclose my information as needed for these purposes.
- I have the right to leave the program at any time. I understand that any information shared prior to my leaving the program will be kept by WWC & WISEWOMAN. All information is kept private.
- If I am diagnosed with breast or cervical cancer, I understand that if I have health insurance that covers cancer treatment, I will not be eligible for the Breast and Cervical Cancer Medicaid Program.
- WWC & WISEWOMAN do not pay for some tests and do not pay for ANY cancer treatment.

My responsibilities are as follows:

- If I no longer want to take part in the WWC or WISEWOMAN programs, I will inform my healthcare provider IN WRITING and I will be withdrawn from the program. This authorization expires when I formally withdraw from the programs.
- I have talked to someone from this clinic about what choices I have and understand that I may have to pay for some tests and treatment that WWC & WISEWOMAN do not cover.
- My provider, clinic, hospital, laboratory, and mammography center may share my information with: _____ and CDPHE.
(contract agency name)

SIGNATURE

NAME (PLEASE PRINT)

DATE

PLEASE ANSWER THE FOLLOWING SCREENING QUESTIONS

1. When was your last menstrual period? _____

2. Have you ever had a pap smear before? Yes _____ No _____

Where? _____

When? _____

3. Have you had a Hysterectomy? Yes _____ No _____

4. Are you allergic to Latex? Yes _____ No _____

5. Do you experience any of the following barriers to seek medical care? (Please check ALL the barriers you experience)

- Transportation
- Language
- Child/Dependent Care
- Cultural Beliefs that prevent you from seeking care
- Disabled/Mobility issues
- Housing
- Financial problems
- Lack of information about PAP and Mammography testing
- Behavioral health issues
- Lack of someone to support you
- Other: _____