



ENROLLMENT AND CONSENT FORM



Last Name
 First Name
 Date of Birth
 Age
 Day Phone

You are eligible for the **Breast & Cervical Health** and **WISEWOMAN** programs if your household income falls between any of the levels below. You are eligible for sliding discount if your household income falls within the Sd1 through Sd4 levels below.

Please check all that apply:

- I am applying for:
 Breast & Cervical Health Program (age 18 - 64)
 WISEWOMAN (age 30 - 64)
 Sliding Discount
 Not Applying

Please circle your household size and income in the column(s) below:

Estimated Average Monthly Income (All money coming into your household monthly, do not include dividends)											
Household Size (All people who live on this income)	Breast & Cervical Health and/or WISEWOMAN Program(s) Levels 1- 5										
	Sliding Discount Levels 1- 4 Only								Level 5 (201-250%)		Not Eligible
	Level 1 (100-125%) Between		Level 2 (126-150%) Between		Level 3 (151-175%) Between		Level 4 (176-200%) Between		Level 5 (201-250%) Between		
1	\$ 1,020	\$ 1,275	\$ 1,276	\$ 1,530	\$ 1,531	\$ 1,785	\$ 1,786	\$ 2,040	\$ 2,041	\$ 2,550	\$ 2,550
2	\$ 1,375	\$ 1,719	\$ 1,720	\$ 2,062	\$ 2,063	\$ 2,406	\$ 2,407	\$ 2,750	\$ 2,751	\$ 3,438	\$ 3,438
3	\$ 1,729	\$ 2,161	\$ 2,162	\$ 2,593	\$ 2,594	\$ 3,026	\$ 3,027	\$ 3,458	\$ 3,459	\$ 4,323	\$ 4,323
4	\$ 2,016	\$ 2,520	\$ 2,521	\$ 3,024	\$ 3,025	\$ 3,528	\$ 3,529	\$ 4,032	\$ 4,033	\$ 5,040	\$ 5,040
5	\$ 2,437	\$ 3,046	\$ 3,047	\$ 3,655	\$ 3,656	\$ 4,265	\$ 4,266	\$ 4,874	\$ 4,875	\$ 6,093	\$ 6,093
6	\$ 2,696	\$ 3,370	\$ 3,371	\$ 4,044	\$ 4,045	\$ 4,718	\$ 4,719	\$ 5,392	\$ 5,393	\$ 6,740	\$ 6,740
7	\$ 3,145	\$ 3,931	\$ 3,932	\$ 4,717	\$ 4,718	\$ 5,504	\$ 5,505	\$ 6,290	\$ 6,291	\$ 7,863	\$ 7,863
8	\$ 3,500	\$ 4,375	\$ 4,376	\$ 5,250	\$ 5,251	\$ 6,125	\$ 6,126	\$ 7,000	\$ 7,001	\$ 8,750	\$ 8,750

- I am applying for the **Breast & Cervical Health** and/or **WISEWOMAN** program(s) and I decline to provide income information.
 If you are applying for the sliding discount, then you must provide your income information and verification. You must supply insurance information if you chose to decline income information.

Please check ALL that apply:

No private insurance
 Insurance does not cover preventive care
 Deductible is \$2,500 or greater
 Alaska Native or American Indian
 Caucasian
 Asian
 Native Hawaiian or Pacific Islander
 African American
 Unknown

Please sign below acknowledging that you have read, understand and agree to all the conditions outlined on the reverse side of this form for the **Breast & Cervical Health** and **WISEWOMAN** eligibility policies. All information that I have provided is correct to the best of my knowledge.

Signature: _____ Date: _____ Witness: _____ Date: _____

How did you hear about our program?
 Newspaper
 Friend
 Radio
 Other Health Provider
 Poster
 Other



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I understand that the BCHP and WISEWOMAN programs can provide screening for breast and cervical cancer, heart disease and stroke.

I understand that BCHP screening consists of a clinical breast exam, pelvic exam, and Pap smear for women between the ages of 18 to 64. BCHP screening includes a mammogram for those women ages 40 to 64.

I understand WISEWOMAN screening consists of height, weight, waist size, blood pressure, tobacco use, and nutritional and physical activity habits for women between the ages of 30 to 64. A blood sample will also be drawn to test for cholesterol and glucose levels.

I understand some specific follow-up diagnostic tests will be provided if necessary, but the BCHP and/or WISEWOMAN 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.

I understand that if I am not a Native Beneficiary I will be billed for any services other than those defined above.

I understand that in order to participate in some of the WISEWOMAN activities, I may need to receive medical clearance from my provider during a follow-up appointment.

I understand that many WISEWOMAN activities are held in public settings and that my voluntary participation in any of these public settings cannot be considered private.

I understand I may drop out of either the BCHP or WISEWOMAN program at any time.

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

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

*The State of Alaska recently passed legislation that enables women who are enrolled in the SEARHC BCH program and found to be in need of treatment for either breast or cervical cancer, or cervical dysplasia, may be eligible for the treatment costs to be covered through Medicaid.

For Office Use Only:	
Verified by PAR: _____	Date: _____ Screening Site: _____
<input type="checkbox"/> WW and WHG entered into RPMS	<input type="checkbox"/> WHG only entered into RPMS
<input type="checkbox"/> AIF entered into RPMS	<input type="checkbox"/> Beginning and End Eligibility Date