Patient Information

(Patient Keeps This Page)

Next Steps:

- Thank you for filling out the registration packet.
- Please make sure all pages needing signatures have been signed, and income has been written in. Please have someone sign witness line.
- If any of the above is not completed, it will take longer to process your packet.
- After we receive the packet, we may call you with questions.
- After we verify your eligibility for our program, your information will be forwarded to the medical partner you selected.
- You will be contacted directly by UMC or Covenant to set up your appointment.
- Please allow up to ten business days to hear from them. They may have additional questions, so please be prepared for the phone call to take several minutes.
- After 10 business days, if you have not heard directly from UMC or Covenant, please contact them. You will need to know your date of birth and referring physician or clinic.
- After your appointment has been set, please call UMC or Covenant for directions, questions or to change your appointment time.

YWCA WHI (806)687-8858
Covenant Arrington Comprehensive Breast Center (806)725-7908
UMC Breast Imaging Center (806)775-8660
For assistance getting medical insurance visit the following website:
https://www.healthcare.gov/
Or call 1-800-318-2596 for questions or further assistance.

YWCA of Lubbock

Women's Health Initiative

YWCA WHI
1500 14th St.
Lubbock, Texas 79401
Phone: (806) 687-8858
Fax: (806) 784-0698

eliminating racism
empowering women
ywca

Registration Form
Women's Health Initiative

Date: _____ Name (Last, First, middle, Maiden)_____

Age: _____ Date of Birth_____ SS #_____

Mailing Address: _____ City: _____

Zip Code: _____ County: _____ Phone: _____

Can we text you? Y___N___ Are you employed? Y___N___ If yes, can we call you at work? Y ___N___

Place of Employment: _____ Work Phone_____ Ext_____

Days and Hours Worked: _____

Email Address: _____

Alternate Contact: _____ Relationship_____ Phone_____

_____

Client Information:

Female___ Male___ Other (specify) _____

Ethnicity: Hispanic or Latina ____ Not Hispanic or Latina____

Race: Black____ White ____ American Indian ____ Asian ____ Other(specify) _____

Primary Language Spoken: English ____ Spanish ____ Other _____

Were you born in the USA? Y___N___ If no, where were you born? _____

If no, are you a legal resident? Y____N____ If yes, since when?(month, day, year) _____

Number of people living in household: _____ Total monthly income (before taxes): $_____

Do you have Medicare? Y____N____ Medicaid? Y____N____ Women's Health Medicaid? Y ____N_____

Insurance? Y____N____ Do you receive any financial medical assistance? (Specify)_____

How many times have you used the YWCA WHI to access breast health screening or cervical services?

First Time____ Second Time____ Third Time____ More than 3 times (write number)_____

What is the highest level of education completed or the last year of school you attended?

GED____ High School Diploma____ College Degree____ No formal education _____

<u>Provider Preference (for Mammogram)</u>

If you are being referred for a mammogram, check the provider you prefer.

UMC Breast Imaging_____ Covenant's Joe Arrington Comprehensive Breast Center_____

Covenant Mobile Unit _____

Cervical Screening History

Date of prior pap test: _____ Results: Negative ____Abnormal ____ Unknown____

Have you ever had an abnormal pap? Y____N____ If yes, when?(month, date, year) _____

Circle any of the following if they apply or have ever applied to you.

HPV HIV Cervical Dysplasia Immunocompromised Cervical Cancer

Are you currently pregnant? Y____N____ If yes, due date_____ Are you post-menopausal? Y____N____

Breast Screening History

Have you had a mammogram? Y_____N____ If yes, date _____where_____

Results: Normal_____ Abnormal_____ Unknown_____

Have you ever had a breast biopsy? Y____N____ If yes, what type_____ which breast_____

Have you ever been diagnosed with breast cancer? Y____N____ Not Sure_____

If yes, when?(month, date, year) _____

Has your mother, sister's, or daughter ever been diagnosed with breast cancer? Y____N____

If yes, at what age were they diagnosed? _____

Have you ever had a Hysterectomy? Y____N____ If yes, when? _____ Reason: _____

Medical Health Screening

Do you have any disabilities? Y____N____ If yes, explain_____

Do you have a history of smoking? Y____N____ If yes, how long?_____ How many per day? _____

How do you identify yourself?

Heterosexual(straight)____ Bisexual_____ Lesbian_____ Transgender _____

Number of Pregnancies_____ Number of Births _____ Age at first birth _____

What was the last date of your menstrual period?_____ Age of first menstrual period? _____

YWCA WOMEN'S HEALTH INITIATIVE

We do not discriminate against any person on the basis of race, color, natural origin, sex, age, religion, or disability; in our program of services.

Consent for Services

By my signature below, I consent to services provided through the Women's Health Initiative Program of the YWCA of Lubbock necessary for the early detection of breast and cervical cancer.

Consent for Release of Information

I hereby authorize University Medical Center, Texas Tech University Health Sciences Center, Joe Arrington Cancer Center, Covenant Health Systems, Covenant Medical Group, and/or my private physician/healthcare clinic to disclose a report of any screening or diagnostic procedures done for the purpose of early detection of breast/cervical cancer to the aforementioned medical providers and /or my private physician/healthcare clinic.

The disclosure of information authorized herein is made for the purpose of follow-up. Should I need further diagnostic procedures and such disclosure shall be limited to the following specific types of information:

- Results of clinical breast and /or cervical examination, mammography Screening results, Pap test results, biopsy results and any further diagnostic procedures necessary for the early detection of breast/cervical cancer.
- I agree for non-identifying demographic data to be used by the YWCA for reporting purposes.

I understand that my participation in the YWCA Women's Health Initiative means that I will be asked to have additional evaluation or initiation of treatment if any abnormalities are found in my Pap test or mammogram. I agree to case management and further testing until a final diagnosis is made.

By agreeing to receive services through the YWCA of Lubbock Women's Health Initiative, I understand that I am agreeing to the release of information to the Med- IT (Medical Information Tracking System) records system as well as to the YWCA of Lubbock.

*_____ _____

Client Signature Date of Signature

_____

Printed Name of Client

*_____ _____

Witness Signature (other than client) Date of Signature

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form

Use with HOUSEHOLD Worksheet (Form EF05-13227)

TEXAS Department of State Health Services

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address	
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP

a) Please contact me by: (check all that apply) ☐ Mail ☐ Phone ☐ Email

b) Do you – or anyone in your household – have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? ☐ Yes ☐ No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that anyone in your household has received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐ Medicaid for Pregnant Women ☐ TWHP ☐ None

PART II - HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race	Ethnicity	Relationship
1.						
2.						
3.						
4.						
5.						
6.						

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. ☐ Yes ☐ No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household or me.

Signature – Applicant _____ Date _____

Signature – Person who helped complete this application _____ Relationship to Applicant _____ Date _____

TEXAS Health and Human Services Commission

Texas Health and Human Services Commission (HHSC)
Breast and Cervical Cancer Services (BCCS)

Patient Navigation Form

Contractor, Clinic Name:	Patient Navigator:	Patient ID #:	Chart #:

CLIENT INFORMATION

Patient Name:	Date of Birth:	Daytime Phone:
Alternate Contact Name:	Relationship:	Daytime Phone:

PATIENT NAVIGATION CONSENT - Required for patients receiving navigation services

I understand and agree to have ongoing assessment for needs and care coordination planning, and may need additional evaluation because my test results are abnormal.

Signed: _____ Date: _____

FOR AGENCY USE ONLY - PATIENT NAVIGATION WORKSHEET

Contractors may use an approved alternate patient navigation form if worksheet content and client consent to navigation are included. Alternate forms must be submitted to HHSC for consideration and written approval must be kept on file for Quality Assurance visits.

Date Started:	Screening/Diagnostic Results:	
Navigation Need	**Barriers**	**Activities**
☐ MBCC Application ☐ Cervical Dysplasia Treatment ☐ Breast Diagnostics ☐ Cervical Diagnostics	☐ Childcare ☐ Fear ☐ Language barrier ☐ Pregnant ☐ Education ☐ Transportation ☐ Financial ☐ Psychosocial ☐ Schedule/Work ☐ Family Issues ☐ Other _____	☐ Provide Education ☐ Financial Assistance Referral ☐ Social Work Referral ☐ Psychosocial Support ☐ Translator/Language Services ☐ Schedule Appointment ☐ Transportation Assistance/Referral ☐ Community Resources Referral ☐ Flex Appointment Time/Place ☐ Childcare Resources Referral ☐ Pregnancy Resources Referral ☐ Other _____

REFERRALS AND FOLLOW UP

Activity	Service Provided	Date of Service	Follow Up Date	Outcome of Service or Referral

DATE CLOSED: _____ REASON CLOSED: _____