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
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 ___________

___________________________________________________________________________

Provider Preference (for Mammmogram)

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 ________________________________
Section I. Applicant Information

This form can be used to apply for BCCS or FPP.

<table>
<thead>
<tr>
<th>Name (Last, First, Middle)</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Race/Ethnicity</th>
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<tr>
<th>Email Address</th>
<th>Primary Area Code and Phone No.</th>
<th>Alternate Area Code and Phone No.</th>
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<tr>
<th>Home Address (Street, Apt. or P.O. Box)</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP Code</th>
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Communication Preferences

Please contact me by: ................................................................. ☐ Mail ☐ Phone ☐ Email:

Preferred language: ................................................................. ☐ English ☐ Spanish ☐ Other

Section II. Applicant Health Care Information

I have comprehensive health care coverage. This includes Medicaid, Medicare, Children’s Health Insurance Program (CHIP), Veterans Benefits, TRICARE, private insurance, etc. (If yes, an authorized program representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.) .................................................................  ○Yes  ○No

Check all benefits that you receive:

☐ Supplemental Nutrition Assistance Program (SNAP)  ☐ CHIP Perinatal

☐ Women, Infants and Children (WIC) Program  ☐ Medicaid for Pregnant Women

☐ Healthy Texas Women (HTW) Program  ☐ Other

Section III. Household Information

Number of people in the household. _______ This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s), if applicable.

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<tr>
<th>Name (Last, First, Middle)</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>Relationship</th>
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Household Income Information

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<th>Name of person receiving money</th>
<th>Name of employer/person who provides the money</th>
<th>Amount of money received per month</th>
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<th>Type of Deduction</th>
<th>Deduction Amount</th>
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Section II. Applicant Health Care Information

I have read the Rights and Responsibilities statements.

Privacy Notification

With few exceptions, you have the right to request information that the state of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. (Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at https://veterans.portal.texas.gov.

Acknowledgment

I understand that this application is a legal document and that by signing this form, I am stating that, to the best of my personal knowledge, all facts included are true and correct. I understand that giving false information could result in disqualification or reimbursement for the cost of services and that if I am approved to receive program services, I must comply with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

* Please Initial

Coverage Attestation

I attest that, to the best of my knowledge, I have no other coverage than what is listed in Section II, Applicant Health Care Information. I authorize the program to bill the coverage sources listed for any services provided.

* Please Initial

Statement of Release of Information

I authorize the release of income and medical information to and by the Texas Health and Human Services Commission and the provider, as necessary, to determine eligibility and to coordinate, render and bill for services.

* Please Initial

Applicant Signature ___________________________ Date ___________________________
# Patient Navigation Form

<table>
<thead>
<tr>
<th>Contractor, Clinic Name:</th>
<th>Patient Navigator:</th>
<th>Patient ID #:</th>
<th>Chart #:</th>
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</table>

## CLIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
<th>Daytime Phone:</th>
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<tr>
<td>Alternate Contact Name:</td>
<td>Relationship:</td>
<td>Daytime Phone:</td>
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## 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.

<table>
<thead>
<tr>
<th>Date Started:</th>
<th>Screening/Diagnostic Results:</th>
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### Navigation Need
- [ ] MBCC Application
- [ ] Cervical Dysplasia Treatment
- [ ] Breast Diagnostics
- [ ] Cervical Diagnostics

### Barriers
- [ ] Childcare
- [ ] Fear
- [ ] Language barrier
- [ ] Pregnant
- [ ] Education
- [ ] Transportation
- [ ] Financial
- [ ] Psychosocial
- [ ] Schedule/Work
- [ ] Family Issues
- [ ] Other ______

### Activities
- [ ] 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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Service Provided</th>
<th>Date of Service</th>
<th>Follow Up Date</th>
<th>Outcome of Service or Referral</th>
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DATE CLOSED: ___________________ REASON CLOSED: ___________________

Updated 09/2016