YWCA OF LUBBOCK

WOMEN'S HEALTH INITIATIVE

YWCA Women's Health Initiative
ywcalubbock.org

P.O. Box 94136, Lubbock, TX 79493
806.687.8858 | fax 806.784.0698

REGISTRATION FORM

Client Information

Date _____ Date of Birth _____ Age _____ SSN _____

Name (First, Middle, Last, Maiden) _____

Street Address _____ City _____

Zip Code _____ County _____ Phone _____

May we text you at the phone number listed above? Yes No Are you employed? Yes No

Email Address _____

Race Black White American Indian Asian Other _____

Ethnicity Hispanic/Latina NOT Hispanic/Latina

Gender Female Male Transgender Nonbinary Other _____

How do you identify? Heterosexual Lesbian Gay Bisexual Other _____

Primary Language Spoken English Spanish Other (specify) _____)

Were you born in the United States? Yes No If no, where were you born? _____

If no, are you a legal resident? Yes No If yes, since when? _____

Number of people living in your household _____ Total monthly income before taxes $_____

Do you have Medicare? Yes No Medicaid? Yes No Women's Health Medicaid? Yes No

Insurance? Yes No Do you receive any medical financial assistance (specify)? _____

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

____ Grade GED High School Diploma College Degree No Formal Education

Alternate Contact

Name (First and Last) _____ Relationship _____ Phone _____

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Provider Preference (for mammogram)

University Medical Center (UMC) Breast Imaging Covenant Joe Arrington Comprehensive Breast Center

Cervical Screening History

Date of prior pap test _____ Results Negative Abnormal Unknown

Date of prior HPV test _____ Results Negative Abnormal Unknown

Have you ever had an abnormal pap test? Yes No If yes, when (month/day/year) _____

Have you ever had cervical cancer? Yes No If yes, when (month/day/year) _____

Are you currently pregnant? Yes No If yes, due date (month/day/year) _____

Are you post menopausal? Yes No

Breast Screening History

Have you had a mammogram? Yes No If yes, when (month/day/year) _____

Where? _____ Results Normal Abnormal Unknown

Have you ever had a breast biopsy? Yes No

If yes, what type? _____ Which breast? Left Right

Have you ever been diagnosed with breast cancer? Yes No Not Sure

If yes, when (month/day/year) _____

Has your mother, sister(s) or daughter ever been diagnosed with breast cancer? Yes No

If yes, at what age were they diagnosed? _____

Have you had a hysterectomy? Yes No If yes, when and why? _____

Medical Health Screening

Do you have any disabilities? Yes No If yes, explain _____

Do you have a history of smoking or vaping? Smoking Vaping

If yes, for how long? _____ How many cigarettes or vape puffs per day? _____

Have you given birth? Yes No If yes, age at first birth _____

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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 Services

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 or 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, such disclosure shall be limited to the following specific type 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.
- for non-identifying demographic data to be used by the YWCA of Lubbock Women's Health Initiative for the purpose of reporting.

I understand that my participation in the YWCA of Lubbock 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 the YWCA of Lubbock Women's Health Initiative.

X _____ _____

Client Signature Date of Signature

_____

Printed Name of Client

X _____ _____

Witness Signature *(someone other than client)* Date of Signature

TEXAS
Health and Human Services

Form 1065
May 2019-E

Breast and Cervical Cancer Services (BCCS) Program or Family Planning Program (FPP)

Eligibility Application

Section I. Applicant Information

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

Name (Last, First, Middle)	Sex ◯ Male ◯ Female	Date of Birth	Race/Ethnicity
Email Address	Primary Area Code and Phone No.	Alternate Area Code and Phone No.	
Home Address (Street, Apt. or P.O. Box)	City	County	State / ZIP Code

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)
- ☐ Women, Infants and Children (WIC) Program
- ☐ Healthy Texas Women (HTW) Program
- ☐ CHIP Perinatal
- ☐ Medicaid for Pregnant Women
- ☐ 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.

Name (Last, First, Middle)	Date of Birth	Sex	Race/Ethnicity	Relationship

Household Income Information

Name of person receiving money	Name of employer/person who provides the money	Amount of money received per month

Type of Deduction	Deduction Amount

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

_____ Please Initial

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 am approved to receive program services, I must comply with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

Coverage Attestation

_____ Please Initial

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.

Statement of Release of Information

_____ Please Initial

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.

X _____ Applicant Signature

_____ Date