Please Fill Out All Questions on Packet

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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YWCA OF LUBBOCK Women's Health Initiative REGISTRATION FORM - PAGE 2

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

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Form 1065
January 2025

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

Eligibility Application

Section I. Applicant Information

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

Name (Last, First, Middle)	Sex ◯ Male ◯ Female	Date of Birth	Race or Ethnicity

Home Address (Street, Apt., or P.O. Box)	City	County	State	ZIP Code

Primary Area Code and Phone No.	Secondary Area Code and Phone No.	Email

How did you learn about this program? For example, social media, community health worker, community-based organization

Communication Preferences

How may we contact you? Check all that apply	Preferered Language:
☐ Email ☐ Phone ☐ Mail	◯ English ◯ Spanish ◯ Other

Section II. Household Information

List all household members

Name (Last, First, Middle)	Date of Birth	Sex	Race or Ethnicity	Relationship	
					+ –
					+ –

Section III. Adjunctive Eligibility

Check all benefits you or a member of your household receives:

☐ Children's Health Insurance Program Perinatal (CHIP-P)

☐ Women, Infants, and Children (WIC) Program

☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Children's Health Insurance Program (CHIP)

☐ Other

Section IV. Household Income

Name of Household Member Who Receives Money	Name of Employer or Person Who Provides Money	Type of Income	Amount of Money Received Per Month	
				+ –
				+ –

Type of Deduction	Deduction Amount

Section V. Applicant Acknowledgement

Privacy Notification

With few exceptions, you have the right to request information 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 determined to be incorrect per 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 U.S. Armed Forces, Reserves or National Guard may be eligible for additional benefits and services. For more information, review the Texas Veterans Portal at https://veterans.portal.texas.gov.

Coverage Attestation

______________ I attest that I, the primary applicant, have no other health insurance coverage than what is listed in Section III, Adjunctive Eligibility, of this application.

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.

Initial

Statement of Release of Information

______________ HHSC's grantee has consent to send automated phone or text messages to me abcut my Medicaid for Breast and Cervical Cancer application and eligibility.

Initial

I understand 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 giving false information could result in disqualification or reimbursement for the cost of services. I understand if I am approved to receive program services I must comply with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

______________________________ ______________________________

Applicant Signature Date