

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

Attendee 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 _____

YWCA OF LUBBOCK Women's Health Initiative REGISTRATION FORM - PAGE 3

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



Please Fill Out all Questions

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

Form 1065
September 2026

Use this form to apply for BCCS or FPP.

Section 1 – Applicant Information

Last, First and Middle Name	Sex ☐ Male ☐ Female	Date of Birth	Race or Ethnicity	
Home Street Address or P.O. Box	City	State	County	ZIP Code
Primary Area Code and Phone No.		Secondary Area Code and Phone No.		
Email Address				
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. ☐ Email ☐ Phone ☐ Mail				
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____				
Service Members				
Have you ever served in the U.S. Armed Forces or Texas Military Forces, regardless of length of service or type of discharge? ☐ Yes ☐ No ☐ Prefer not to answer				

Section 2 – Household Information

List all household members.

Last, First, Middle Name	Date of Birth	Sex	Race or Ethnicity	Relationship
				—
				—
				—
				—

Section 3 – Benefits

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: _____

*CHIP-P may only be used as adjunctive eligibility for FPP.

†Client is only eligible for FPP if the applicant's child, who must be considered part of the household, is enrolled in CHIP.

Section 4 – 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
			—
			—

Please Initial and Sign

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Type of Deduction	Deduction Amount
	-

Form 1065
9-2026

Section 5 – 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 on request. You also have the right to ask the state agency to correct any information determined to be incorrect per Government Code, Sections 552.021, 552.023, 559.003 and 559.004.

Important Information for Former Female Military Service Members

If you are an adult woman who served in the military, you may be entitled to more services. Visit the TVC's Women Veterans Program website at tvc.texas.gov/women and the Texas Veterans Portal at 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 3, 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 (HHSC) 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 about 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