



## Well Woman HealthCheck Program (WWHP) Demographic and Eligibility Form

- Clinical Services
- Care Coordination

**Contractor/Location:** \_\_\_\_\_ **Provider:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Name:** \_\_\_\_\_

**Maiden Name:** \_\_\_\_\_ **Other Names Used:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ (MM/DD/YYYY) **Age:** \_\_\_\_\_ **Sex:**  Male  Female

**Place of Birth:** **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Country:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Apt. #** \_\_\_\_\_ **City:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_ **Nighttime Phone:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Apt. #** \_\_\_\_\_ **City:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

### Demographic Information

<b>What language do you speak at home?</b> <i>(You may identify more than one)</i> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Tribal: _____ <input type="checkbox"/> Other: _____	<b>What ethnicity are you?</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<b>Which race do you identify with?</b> <i>(Check all that apply)</i> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Eskimo <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White/Blanca <input type="checkbox"/> Other	<b>Have you previously been diagnosed with cancer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, what type?</b> _____
---	--	---	--

**Have you used tobacco or electronic nicotine (tobacco-like) products in the last 30 days?**  Yes  No

**ASHLine referral given**  Yes  No **Refused**

**Disabled:**  Yes  No **Arizona Living Well Institute referral given?**  Yes  No

### Financial Eligibility

Household income (before taxes): \$ \_\_\_\_\_  
 Weekly  Monthly  Annually

Number of people in the household supported by this income: \_\_\_\_\_

Do you have health insurance?  Yes  No

My copay is greater than \$100  
 I cannot afford to meet my insurance plan's deductible

Do you have AHCCCS or Medicare?  Yes  No

If you have Medicare, do you have part A and B?  Yes  No

*If you have insurance or Medicare, please provide the card to your provider so they may photocopy the front and back of the card.*

**ATTACH A PHOTOCOPY OF CARD TO FORM**

### Referral Source

<input type="checkbox"/> American Cancer Society	<input type="checkbox"/> Newspaper
<input type="checkbox"/> Annual	<input type="checkbox"/> Promotora/Mensajeras
<input type="checkbox"/> Brochure/Poster/Flier	<input type="checkbox"/> Radio
<input type="checkbox"/> Church Bulletin	<input type="checkbox"/> Reminder Call/Card
<input type="checkbox"/> Community Event/Health Fair	<input type="checkbox"/> TV
<input type="checkbox"/> Provider/Doctor	<input type="checkbox"/> Self
<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Health Department
<input type="checkbox"/> Internet	<input type="checkbox"/> Unknown

### Eligibility Justification

(If necessary)

Not AHCCCS eligible  Symptomatic

**Please provide the telephone number of one person who does NOT live with you, in the event we are unable to contact you at home.**

Emergency Contact

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

I wish to start/continue receiving services through the Well Woman Health Check Program. The information that I have provided on this form is correct. I understand that if I provided false information, that I may be responsible for all charges resulting from the services I have received and that I may not be able to receive future services from the Well Woman HealthCheck Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Eligibility certified by: \_\_\_\_\_ Date: \_\_\_\_\_