DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44818 (Rev. 05/2017)

STATE OF WISCONSIN
s. 255.075, Wis Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT

Print clearly. Client information in this document is confidential under Wis. Stats 146.82

PERSONAL INFORMATION – Completed by Client

1. Last Name: _____ 2. First Name: _____

3. Middle Initial: _____ 4. Previous Last Name: _____

5. Street Address: _____ 6. City: _____ 7. State: _____ 8. Zip: _____

9. County of Residence: _____ 10. Native American Tribe: _____ 11. Date of Birth: (mm/dd/yyyy) ____ / ____ / ____

12. Client Identification No.: ____ - ____ - ____ 13. Social Security No.: (Optional) ____ - ____ - ____

14. Day Telephone No.: ( ) _____ 15. Other/Cell Phone No.: ( ) _____

16. Mailing Address: (If different from above) _____ 17. City: _____ 18. State: _____ 19. Zip: _____

20. Race: (check all that apply) ☐ White ☐ Black / African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown

21. Ethnicity: ☐ Hispanic / Latina ☐ Non-Hispanic ☐ Unknown

22. Emergency contact, not living with you: _____ 23. Relationship: _____

24. Address: _____ 25. City: _____ 26. State: _____ 27. Zip: _____

28. Contact Person's Day Telephone No.: ( ) _____ 29. Other/Cell Phone No.: ( ) _____

INSURANCE INFORMATION – Completed by Client

30. Do you have Medicaid (including Family Planning Waiver)? ☐ Yes ☐ No 31. Do you have Medicare Part B? ☐ Yes ☐ No

32. Do you have health insurance? ☐ Yes ☐ No 33. Do you have disability health insurance? ☐ Yes ☐ No

HEALTH CARE PROVIDER INFORMATION – Completed by Client

34. Do you have a primary health care provider? ☐ Yes ☐ No 35. If Yes, Name of Provider: _____

36. Clinic Name: _____

37. Street Address: _____ 38. City: _____ 39. State: _____ 40. Zip: _____

41. How did you hear about this program? ☐ WWWP Coordinator ☐ Relative / Friend ☐ Radio / TV ☐ Newspaper ☐ Brochure / Poster ☐ Clinic / Health Care Provider ☐ Fair ☐ Billboard ☐ Bus advertisement ☐ Other

42. CLIENT PARTICIPATION AGREEMENT

I understand and agree to the following: the Wisconsin Well Woman Program (WWWP) will use the personally identifiable information only for program enrollment, program administration and case management. I give WWWP permission to release my medical information to the Local Coordinating Agency (LCA), other service providers, referral agencies and the State of Wisconsin. I understand that WWWP pays for preventive screening services, but does not pay for medical treatment services. I have seen the current program eligibility criteria and, to the best of my knowledge, my annual income does not exceed them. All of the information I have given is true and correct. I will inform the WWWP LCA if I move or if I no longer wish to participate.
I understand the enrollment is valid for one (1) year from the date signed.

43. **SIGNATURE – Applicant:** _____ 44. **Date Signed:** _____

45. **SIGNATURE – Witness:** _____ 46. **Date Signed:** _____

Office Use Only

47. ☐ Enrollment ☐ Re-Enrollment ☐ Dis-Enrollment Date (mm/dd/yyyy): / / ☐ Deceased Date of death (mm/dd/yyyy): / /

48. Certifying Agency No.: _____ 49. Certifying Agency Name: _____

50. Enrollment Start Date (mm/dd/yyyy): / / 51. Enrollment End Date (mm/dd/yyyy): / /

52. Age ≥ 35: ☐ Yes ☐ No 53. Income ≤ 250% of Federal Poverty Level: ☐ Yes ☐ No 54. ☐ Uninsured 55. ☐ Underinsured (See insurance info above)

56. Translation services needed: ☐ Yes ☐ No 57. Language: 58. Household size:

61. ☐ Meets Eligibility Requirements Eligibility Confirmed By:
62. Printed name: _____ 63. Signature: _____