DEPARTMENT OF HEALTH AND FAMILY 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: ______