Washington State Department of HEALTH

DOH 342-045 JAN 2024 ENG

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

WISEWOMAN™

BCCHP and WISEWOMAN ENROLLMENT FORM

Please Print

Authorization #

Last Name	**First Name**	**MI**

Date of Birth

Phone Number(s): **Main:** **Emergency:**

Is it OK to leave a voicemail? ☐ Yes ☐ No

Address

City	**State**	**Zip Code**	**County** Select County

Gender: ☐ Female ☐ Male ☐ Transgender/Trans Man ☐ Transgender/Trans Woman ☐ Gender Non-Binary ☐ Genderqueer ☐ Agender ☐ Other:

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay ☐ Bisexual ☐ Queer/Pansexual ☐ Unsure ☐ Other:

Authorized for:
☐ CBE ☐ Mammogram
☐ Cervical/Pelvic (Pap, HPV, etc.)
☐ WISEWOMAN Services

Authorization Date:

Clinic / Screening Site

Appointment Date: **Time:**

Clinic Chart #

What services are you interested in? ☐ Breast ☐ Cervical ☐ WISEWOMAN Program *(not available in all service areas)*

Do you have any problems with your breasts? ☐ Yes ☐ No
If yes, what problem(s)?_____

Do you have a disability? ☐ No ☐ Yes **Check all that apply:** ☐ Physical ☐ Hearing ☐ Visual ☐ Developmental ☐ Other:

If "Yes", does this cause difficulty in accessing services? ☐ Yes ☐ No ☐ Don't Know/Not Sure

Do you have health insurance (including Apple Health)**?** ☐ Yes ☐ Medicare Part B ☐ No

Company:	**Deductible:** $	**Policy/Provider One Number:**

Are you eligible for Apple Health? ☐ Yes ☐ No ☐ Don't Know/Not Sure ☐ Already Enrolled *(skip next question)*

Would you like to be enrolled on Apple Health, if eligible? ☐ Yes ☐ No Reason:

What is your household income <u>before</u> taxes? $ ☐ Monthly ☐ Yearly

What is your family size? Include spouses, children, and any legally dependant relatives. _____

What is your primary language? **Do you need an interpreter?** ☐ Yes ☐ No

Which race(s) do you identify with? (Mark all that apply)
☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native (specify tribe:)
☐ White or Caucasian ☐ Native Hawaiian or other Pacific Islander (specify:) ☐ Unknown/Other

Do you consider yourself Latina/Latino or Hispanic? ☐ Yes ☐ No

What is the highest grade of school you have completed? (number of school years) _____

Are you NEW to BCCHP? ☐ Yes ☐ No

If yes, how did you learn about BCCHP? (Select one) ☐ Clinic ☐ Community organization ☐ Outreach worker ☐ Friend or relative ☐ Internet search ☐ Other

Please FAX form to BCCHP Prime Contractor at:

To request this document in another format, call 1-800-525-0127.
Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.