



CLIENT PROFILE TOOL

(Internal Use)

AGENCY #	CHART #	eCaST ID
ENROLLMENT/RE-ENROLLMENT DATE	<input type="checkbox"/> I HAVE VERIFIED THIS PATIENT'S LAWFUL PRESENCE DOCUMENT IS CURRENT.	

TOBACCO SCREENING

Screened Positive., agency faxed referral Screened Negative

Screened Positive., client declined referral Client was not screened

UNINSURED CLIENT: REFERRED FOR INSURANCE (mark all that apply)

Medicaid Other: _____

Connect for Health Colorado Client not referred

PATIENT INSTRUCTIONS: Please fill in each part below. *Information is required for enrollment into the Women's Wellness Connection program.

IDENTIFICATION

LAST NAME*	FIRST NAME*	MIDDLE NAME*	MAIDEN NAME*
LAST 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER*		DATE OF BIRTH*	AGE*

WHAT ETHNICITY ARE YOU? CHOOSE ONE BELOW.*

I am Latina and/or Hispanic. I am not Latina or Hispanic. I am not sure if I am Latina or Hispanic.

WHAT RACE(S) ARE YOU? CHECK ALL THAT ARE TRUE.*

Black/African American Asian Pacific Islander

White Alaska Native I am not sure

American Indian (Tribe: _____) Aleutian Islander Other: _____

Native Hawaiian

ENROLLMENT

<p>DO YOU HAVE PRIVATE INSURANCE OR MEDICAID?*</p> <p><input type="checkbox"/> Yes, I have Medicaid.</p> <p><input type="checkbox"/> Yes, I have private insurance.</p> <p> Check below if any are true.</p> <p> <input type="checkbox"/> But I have a high deductible.</p> <p> <input type="checkbox"/> But does not cover cancer</p> <p><input type="checkbox"/> No, I do not have private insurance or Medicaid.</p>	<p>DO YOU HAVE MEDICARE?*</p> <p><input type="checkbox"/> Yes, I have part A only.</p> <p><input type="checkbox"/> Yes, I have parts A and B.</p> <p><input type="checkbox"/> No, I do not have Medicare.</p>
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To the best of my knowledge, the GROSS MONTHLY (before taxes) income for my household is:*	Number of people living on this income including myself (this may include people not living in you house):*
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CONTACT

HOW DID YOU HEAR ABOUT THE WOMEN'S WELLNESS CONNECTION FREE BREAST AND CERVICAL SCREENING EXAMS?

Brochure / Poster Newspaper Ad American Cancer Society Representative

Clinic Staff / Physician Patient Navigator Other

Friend / Family Member Radio Ad

Health Fair TV Ad

Hotline (866-951-9355) Website

PLEASE PROVIDE THE FOLLOWING NUMBERS WHERE WE CAN REACH YOU:	Mailing Address:		
Home Phone number	City*	State*	Zip*
Work Phone number	County*		
Cell Phone number	Email Address		
<p>Emergency Contact</p> <p>List a phone number and name for someone who could call you if your phone number changes in the future or in an emergency:</p>			