

Clinic use only

Patient ID number (<i>provider's record number</i>) :	Enrollment date: / /
Enrolling agency and site:	
Was patient referred to OregonHealthcare.gov to determine potential eligibility for health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , referral date: / /

Patient information

Last name(s):	First name:	Middle initial:
Date of birth: / /	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Home address:		Apartment number:
City:	State:	ZIP: County:
Phone:		Email:
Other name(s) used: (<i>Last</i>)		(<i>First</i>)

Alternate contact information (*in case we cannot reach you*)

Name:	Relationship to you:
Address:	Apartment number:
City:	State: ZIP: Phone:

Eligibility information

Do you have health insurance or Medicaid? Yes No
 If **yes**, is the following TRUE?
 My health insurance plan does not fully cover breast and cervical cancer screening services, like mammograms and/or Pap tests. Yes No
 My out-of-pocket costs for diagnostic services pose a financial hardship. Yes No

What is your gross monthly household income?
 (*This is the total income before taxes for all household members.*):

How many people live in your household (*including yourself*)?:

Demographic information (*collecting this information to better serve you*)

Hispanic or Latino origin:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to answer
Ashkenazi Jewish origin:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to answer
Language preference:	
Race: (<i>choose one or more</i>)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White
	<input type="checkbox"/> Asian <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Black or African-American <input type="checkbox"/> Unknown
	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Decline to answer
If you chose more than one race, which do you consider your primary race?	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> No primary race identity
	<input type="checkbox"/> Asian <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Black or African-American <input type="checkbox"/> Unknown
	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Decline to answer
	<input type="checkbox"/> White
Disability (<i>check all that apply; optional</i>):	<input type="checkbox"/> Physical/mobility <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Intellectual/cognitive Other: _____

Client consent

By enrolling in the ScreenWise Program, I agree to what is written on this form:

- ScreenWise can pay for breast and cervical cancer screening and diagnostics and may pay for screening services related to heart disease and stroke, if my provider is enrolled to offer these services.
- ScreenWise does not pay for cancer treatment and I may have to pay for tests and treatment that ScreenWise does not cover.
- Being eligible for breast and cervical cancer screening and diagnostic services does not guarantee that I will also receive screening services related to heart disease and stroke.
- I do not have Medicaid, Medicare, or other insurance that will pay for these screening tests.
- ScreenWise has rules about who may enroll in the program. All of the information I have given to the clinic is true as far as I know. If I tell the clinic something that is not true, I may not get these tests and I may have to pay for any tests done.
- ScreenWise, my medical care providers, clinics and/or hospitals may share information with one another about my health care and any related medical care I receive through ScreenWise; and may organize my care and involvement in health coaching, evidence-based lifestyle programs and the Oregon Tobacco Quit Line.
- My information will not be shared with anyone outside of ScreenWise contracted providers and its funders. Any published report will not use my name.
- I understand that I have the right to withdraw from the ScreenWise program by informing my healthcare provider in writing. I understand that any information shared prior to my withdrawal shall be kept by ScreenWise.
- I understand that I may get letters in the mail from my doctor to remind me when it is time for me to go back to my clinic for screening or other tests.
- This enrollment form expires one year after the date I sign it, meaning that I must re-enroll after 12 months to keep getting services.

Client signature:

Date:

Client name (*printed*):

Interpreter signature (*if used*):

Date: