Every Woman's Life

A Virginia Department of Health Program

Client Eligibility Form

PERSONAL INFORMATION			
Last Name	**First Name**	**MI**	**Maiden Name**
SSN (or alien ID)	**Birth Date / /**	**Age**	
Address	**City**	**County**	
State	**Zip**	**Home Phone ( ) -**	
Work Phone ( ) -	**Cell Phone ( ) -**	**Best Time to Call:**	

1. What is your household income before taxes? $ /Year

2. How many people live on this income? (including yourself)

3. Do you have Medicaid? ☐ Yes ☐ No **Medicare?** ☐ Yes ☐ No ➔**If YES** ☐Part A or ☐Part B

4. Private insurance? ☐ Yes ☐ No ➔**If YES, has deductible been met?** ☐ Yes ☐ No

5. Do you now smoke cigarettes? ☐ Every day ☐ Some days ☐ Not at all ☐ Don't know ☐ Don't want to answer

6. Are you planning, thinking, or not thinking about quitting smoking in the next 30 days?
☐ Planning ☐ Thinking ☐ Not thinking ☐ Don't smoke cigarettes ☐ Don't want to answer

7. What is the highest grade of school you completed? ☐<9th ☐ Some high school ☐High school graduate or equivalent ☐ Some college or higher ☐Don't know ☐ Don't want to answer

QUESTIONS FOR NEW CLIENTS ONLY

8. How did you hear about the Every Woman's Life program? ☐ Brochure ☐ Community Health Worker ☐ Family/Friend ☐ Health Fair ☐ Internet/Web ☐Radio/TV/Newspaper ☐ Other:

9. Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

10. Do you describe yourself as: (check ALL that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/ Pacific Islander ☐ Unknown

11. What language do you speak every day?_____

12. Have you ever had a pap test? ☐Yes ☐ No
➔If YES, when was your last Pap test? (month/year) / or ☐ More than 5 years ago ☐ Don't know

13. Have you ever had a mammogram? ☐Yes ☐ No
➔If YES, when was your last mammogram? (month/year) / or ☐ More than 5 years ago ☐ Don't know

OFFICE USE ONLY: Administrative Site: _____ Case Manager: _____
14. Enrollment Site: _____ **15.** Enrollment Date: _____ / _____/ _____
16. Client Status: Active – check one: ☐ New Patient ☐ Rescreen
17. ☐ Inactive due to: (list reason) _____ **18.** Effective Date _____ / _____/ ____
19. Detail: Previous Breast Cancer ☐L Br ☐R Br Hysterectomy for: Cervical Cancer ☐ Non Cancer ☐ Unknown☐
20. ☐ Cervical record only, no breast form submitted ☐ Breast record only , no cervical form submitted
21. Client referred to Virginia Quit Line? ☐ Yes ☐ No

*****Note: For questions 1 through 21, please refer to the <u>Client Eligibility Form Instruction Sheet</u> for guidance and additional information.**