DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4818 (Rev. 06/01/08)

STATE OF WISCONSIN
s. 255.075, Wis Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT

Read instructions on reverse prior to completing this form. 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: _____

FOR DANE COUNTY ONLY - Mail completed form to: WWWP - Public Health, 2705 E. Washington Ave., Madison, WI 53704