WOMEN'S WAY DEMOGRAPHICS

NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION
SFN 54024 (2-2023)

IDENTIFICATION & ENROLLMENT NBCCEDP Paid Patient Navigation ☒ Yes ☐ No Navigation Only ☐ Yes ☐ No

Name (Last, First, Middle Initial)	Social Security Number *	Alternate ID Number
Maiden Name	Any Other Last Name Used	Date of Birth (MM/DD/YYYY)
Enrollment Site	County of Enrollment	Type ☐ Enrollment ☐ Re-Enrollment / Date (MM/DD/YYYY)
Appointment Location/Provider		Appointment Date (MM/DD/YYYY)

MAILING ADDRESS

Street or P.O. Box	City	County	State	ZIP Code
Home Phone Number	Cell Phone Number	Work Phone Number	Email	

ALTERNATE ADDRESS (Secondary)

Street Address	City	State	ZIP Code	Alt Telephone No.

DEMOGRAPHICS

Hispanic / Latino Origin
☐ Yes ☐ No ☐ Unknown

Race(s) (check all that apply)
☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Unknown

Client Status
☐ Active ☐ Deceased ☐ Inactive ☐ Out of Area ☐ Temporarily Inactive

Date of Status Change (MM/DD/YYYY)

Visit Type
☐ 1. Initial ☐ 2. Re-Screen (Annual) ☐ 3. Re-Screen (Follow-up)

Status Notes

Health Insurance (check all that apply)
☐ 1. None Referred to: ☐ Marketplace ☐ Medicaid Expansion ☐ Other: _____
☐ 2. Health Insurance ☐ 3. Medicare A ☐ 4. Other: _____ ☐ 5. Medicaid

Please provide a copy of insurance card (front and back).

Name of Insurance Company	Name of Policyholder	Policyholder Date of Birth (MM/DD/YYYY)
Insurance Benefit Plan Number	Insurance Company Telephone Number	Coverage Dates

Household Status
☐ 1. Never Married ☐ 2. Married ☐ 3. Widowed ☐ 4. Divorced/Separated ☐ 5. Domestic Partner ☐ 6. Other

Are you a smoker/tobacco user?	Are you interested in quitting at this time?	Are you exposed to second-hand smoke?
☐ 1. No ☐ 2. Former ☐ 3. Yes	☐ 1. Yes ☐ 2. No ☐ 3. Not Applicable	☐ 1. Yes ☐ 2. No

Referral offered?
☐ 1. Yes ☐ 2. No ☐ 3. Declined ☐ 4. Not Applicable

Comments

Education
☐ 1. 8th Grade or Less ☐ 3. High School Graduate/GED ☐ 5. Technical School Graduate ☐ 7. College Graduate
☐ 2. Some High School ☐ 4. Some Technical School ☐ 6. Some College ☐ 8. Unknown

Number Living in Household (including yourself)	Total Gross Monthly Household Income (before taxes)

Referral Source (check all that apply)
☐ 1. Self ☐ 3. Outreach ☐ 5. TV Campaign ☐ 7. Newspaper
☐ 2. Provider ☐ 4. WW/BCCP Reminder ☐ 6. Radio Campaign ☐ 8. Other: _____

Continued on back --->

Name (Last, First, Middle Initial)		Date of Birth (MM/DD/YYYY)
Previous Mammogram? ☐ Yes ☐ No	If Yes, Date of Last Mammogram (MM/DD/YYYY)	Implants? ☐ Yes ☐ No
Noticed Changes in Breast? ☐ Yes ☐ No	If Yes, Specify Changes ☐ Skin Different ☐ Nipple Discharge ☐ Other: ☐ Lump ☐ Nipple Inversion	
Do you have a history of breast cancer in your family? (check all that apply) ☐ 1. Mother ☐ 2. Sister ☐ 3. Aunt ☐ 4. Daughter ☐ 5. Grandmother ☐ 6. None ☐ 7. Unknown ☐ 8. Self		

Previous Pap Test? ☐ Yes ☐ No	If Yes, Date of Last Pap	Do you have a history of abnormal Paps? ☐ Yes ☐ No
Have you had a Hysterectomy? ☐ Yes ☐ No	If Yes,Reason for Hysterectomy ☐ Cervical Cancer ☐ Unknown ☐ Cervical Pre-Cancer ☐ Non-Cancer	
Do you still have a cervix? ☐ Yes ☐ No ☐ Unknown		

I verify that, to the best of my knowledge, all information I have provided to *Women's Way* is true and accurate.

Signature	Date (MM/DD/YYYY)
Contact Person (list someone NOT in your household, i.e., relative, neighbor, friend, etc.)	
Relationship to the Applicant	Telephone Number

Questions? Please contact your Enrolling Site Office at 800-449-6636 or 701-328-3398

According to the Privacy Act of 1974, this is to let *Women's Way* clients know that disclosure of a social security number to *Women's Way* is voluntary and it is requested for identification purposes only. Failure to disclose this information will not affect participation in this program.