Women's Wellness Connection Health Navigation, Clinical Services, and WISEWOMAN

CONSENT FORM

COLORADO
Department of Public Health & Environment

AGENCY OR SITE # 76700	eCaST ID	DATE OF BIRTH	AGE
LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME

To the best of my knowledge, the GROSS MONTHLY (before taxes) income for my household is: _____. The number of people living on this income including myself (this may include people not living in your house) is:_____.

CLIENT INSTRUCTIONS: Please read this page carefully before signing at the bottom. By signing this form, you are consenting to enrollment for ALL three programs listed below, if offered by this clinic and if you are eligible. You will remain enrolled as long as you meet eligibility requirements and do not request to be withdrawn.

I am enrolling in Health Navigation through the Women's Wellness Connection (WWC) and I understand the following:
Health Navigation will help me move through the healthcare system to achieve the best possible breast and cervical health results. This program provides Health Navigation breast and cervical appointments depending on my age. Health Navigation does not pay for tests or clinic visits. This program may include help with:

- Learning where to sign up for health insurance
- Understanding test results
- Education about health screening tests
- Scheduling appointments

I am enrolling in Clinical Services through the Women's Wellness Connection (WWC) and I understand the following:
Clinical Services pays for testing in order to screen and diagnose breast and cervical cancer depending on my age. The program does not pay for tests and care that are not related to finding breast or cervical cancer. I have talked to someone at this clinic and understand the choices available to me if cancer is diagnosed. As part of Clinical Services, I understand that I cannot have Medicaid, Medicare, or other health insurance that will pay for these tests or my health insurance has a high deductible or co-pay that I cannot afford.

I am enrolling in the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program and I understand the following:
The WISEWOMAN program pays for screening for cardiovascular disease risk factors (assessment of body mass index, blood pressure, cholesterol, and glucose), risk reduction counseling, medical follow-up (if required) and healthy behavior support options, for which my insurance does not pay, in an effort to prevent cardiovascular disease.

I also understand the following:

- WWC & WISEWOMAN will gather my breast, cervical and cardiovascular health information. This may include: name, age, income, legal presence, insurance status, test results, family and personal medical history. Information obtained by the program is used to find new ways to improve the health of all women.
- I may get communication, including phone calls, letters in the mail or emails to remind me when it is time to go back to my clinic for tests or treatment.
- WWC & WISEWOMAN programs are run by the Colorado Department of Public Health and Environment (CDPHE).
- My health information can be shared for care and treatment purposes for this program with my doctor, clinic, hospital or laboratory, and my doctor, clinic, hospital or laboratory may use and disclose my information as needed for these purposes.
- I have the right to leave the program at any time. I understand that any information shared prior to my leaving the program will be kept by WWC & WISEWOMAN. All information is kept private.
- If I am diagnosed with breast or cervical cancer, I understand that if I have health insurance that covers cancer treatment, I will not be eligible for the Breast and Cervical Cancer Medicaid Program.
- WWC & WISEWOMAN do not pay for some tests and do not pay for ANY cancer treatment.

My responsibilities are as follows:

- If I no longer want to take part in the WWC or WISEWOMAN programs, I will inform my healthcare provider IN WRITING and I will be withdrawn from the program. This authorization expires when I formally withdraw from the programs.
- I have talked to someone from this clinic about what choices I have and understand that I may have to pay for some tests and treatment that WWC & WISEWOMAN do not cover.
- My provider, clinic, hospital, laboratory, and mammography center may share my information with: _____ and CDPHE.
  (contract agency name)

_____
SIGNATURE

_____ _____
NAME (PLEASE PRINT) DATE