



WOMEN'S WAY DEMOGRAPHICS
NORTH DAKOTA DEPARTMENT OF HEALTH
COMMUNITY AND HEALTH SYSTEMS
SFN 54024 (3-2020)

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 <input type="checkbox"/> Enrollment <input type="checkbox"/> 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.
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DEMOGRAPHICS

Hispanic / Latino Origin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Race(s) (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unknown			
Client Status <input type="checkbox"/> Active <input type="checkbox"/> Deceased <input type="checkbox"/> Inactive <input type="checkbox"/> Out of Area <input type="checkbox"/> Temporarily Inactive				Date of Status Change (MM/DD/YYYY)	
Visit Type <input type="checkbox"/> 1. Initial <input type="checkbox"/> 2. Re-Screen (Annual) <input type="checkbox"/> 3. Re-Screen (Follow-up)					
Status Notes					
Health Insurance (check all that apply) <input type="checkbox"/> 1. None Referred to: <input type="checkbox"/> Marketplace <input type="checkbox"/> Medicaid Expansion <input type="checkbox"/> Other: _____ <input type="checkbox"/> 2. Health Insurance <input type="checkbox"/> 3. Medicare A <input type="checkbox"/> 4. Other: _____ <input type="checkbox"/> 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 <input type="checkbox"/> 1. Never Married <input type="checkbox"/> 2. Married <input type="checkbox"/> 3. Widowed <input type="checkbox"/> 4. Divorced/Separated <input type="checkbox"/> 5. Domestic Partner <input type="checkbox"/> 6. Other					
Are you a smoker/tobacco user? <input type="checkbox"/> 1. No <input type="checkbox"/> 2. Former <input type="checkbox"/> 3. Yes		Are you interested in quitting at this time? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Not Applicable		Are you exposed to second-hand smoke? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	
Referral offered? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Declined <input type="checkbox"/> 4. Not Applicable			Comments		
Education <input type="checkbox"/> 1. 8th Grade or Less <input type="checkbox"/> 3. High School Graduate/GED <input type="checkbox"/> 5. Technical School Graduate <input type="checkbox"/> 7. College Graduate <input type="checkbox"/> 2. Some High School <input type="checkbox"/> 4. Some Technical School <input type="checkbox"/> 6. Some College <input type="checkbox"/> 8. Unknown					
Number Living in Household (including yourself)			Total Gross Monthly Household Income (before taxes)		
Referral Source (check all that apply) <input type="checkbox"/> 1. Self <input type="checkbox"/> 3. Outreach <input type="checkbox"/> 5. TV Campaign <input type="checkbox"/> 7. Newspaper <input type="checkbox"/> 2. Provider <input type="checkbox"/> 4. WW/BCCP Reminder <input type="checkbox"/> 6. Radio Campaign <input type="checkbox"/> 8. Other: _____					

Continued on back ---->

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

Previous Pap Test? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of Last Pap	Do you have a history of abnormal Paps? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a Hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Reason for Hysterectomy <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Unknown <input type="checkbox"/> Cervical Pre-Cancer <input type="checkbox"/> Non-Cancer	
Do you still have a cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 800-44-WOMEN or 701-328-2367

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.