Name:_________________________Birthdate ___/___/______ SS#: __________________
mm dd yyyy (Optional)

Address ____
Street City State Zip

The Missouri Department of Health and Senior Services invite you to take part in the Show Me Healthy Women (SMHW) and WISEWOMAN programs. If you qualify and agree, you will receive your breast and cervical cancer examinations and assessments for heart disease and stroke free. WISEWOMAN also provides education resources for improving lifestyle habits to help you lower your risk for heart disease.

If your test results are not normal, this clinic will work with SMHW and/or the Department of Social Services to help you obtain additional tests and, if needed, treatment for cancer. WISEWOMAN does not pay for treatments for heart disease risk factors such as high blood pressure, but the clinic will assist you in obtaining follow-up medical care if needed.

Income/Insurance Information (*Please check all that apply.)*

Are you receiving: Unemployment insurance ☐ WIC ☐ TANF ☐ Food stamps ☐
Medicare Part A ☐ and/or Part B ☐ MO HealthNet (Medicaid) ☐
Have you applied for MO HealthNet (Medicaid)? Yes ☐ No ☐

Question	Answer
Do you have health insurance?	Yes ☐ No ☐
Does your insurance have a deductible?	Yes ☐ No ☐
Can you pay the deductible?	Yes ☐ No ☐
Is your health insurance an HMO?	Yes ☐ No ☐

CLIENT AGREEMENT

I have not supplied documentation of household income. I declare my household income is within SMHW/WISEWOMAN present income guidelines. _______ (**If applicable, please initial**)
I have received the income guidelines and I qualify for SMHW / WISEWOMAN.
A staff person has informed me which tests the SMHW / WISEWOMAN programs cover and possible side effects of the tests.
I understand that the SMHW / WISEWOMAN services will be available to me at no cost.
I understand that my health is my responsibility. I am responsible for keeping my appointments.
I understand that persons associated with SMHW / WISEWOMAN may contact me in receiving medically recommended services.
I need to contact this clinic for my test results.
I understand that no test is 100% accurate.
I agree to participate in both the screening tests and the WISEWOMAN lifestyle education sessions.
I understand that I will be contacted to return in 1 year to see if my health status related to these services has changed.
I have read or had the above read to me. I agree that all the information above is correct.

As a client receiving services funded be Show Me Healthy Women / WISEWOMAN, your protected health care information will be shared with appropriate staff at the Department of Health and Senior Services and other agencies as required by the federal funding source. I acknowledge that I have been given a copy of the Missouri Department of Health and Senior Services Notice of Privacy Policies and have been told where I can obtain any subsequent revisions to this Notice. If this document is signed by the guardian or Durable Power of Attorney for Health Care (DPOA-HC), attach a copy of the Letters Appointing the Guardian or a copy of the Durable Power of Attorney for Health Care.

____ _____/_____/_____
Signature of Client/Guardian Date
Durable Power of Attorney for Health Care (DPOA-HC)