SEARHC CHART #: _____

Sitka Family Medical Center

SEARHC Women's Health Programs

Annual Income Form-2014

Last Name:	First Name:	Date of Birth:	Age:	Day Phone:

You are **ELIGIBLE** if you fill out this form completely AND if your income is **BELOW** the column on the right.

- **Household size** includes all people who live on this income.
- **Household income** is all money coming into your household, not including dividends.

Please circle your household size and income in the column(s) below:

Household Size	Estimated Average Monthly Income	Not Eligible
1	Up to $3,038	More than $3,038
2	Up to $4,096	More than $4,096
3	Up to $5,154	More than $5,154
4	Up to $6,213	More than $6,213
5	Up to $7,271	More than $7,271
6	Up to $8,329	More than $8,329
7	Up to $9,388	More than $9,388
8	Up to $10,446	More than $10,446

Please check ALL that apply:

□ No private insurance □ Insurance does not cover preventive care □ I cannot pay my deductible

□ Alaska Native or American Indian □ White □ Asian □ Hispanic/Latina

□ Native Hawaiian or Pacific Islander □ African American □ Unknown

I have read and agree to all of the conditions outlined on the reverse side of this form.
All information that I have provided is correct to the best of my knowledge.

Signature: _____ Date: _____

How did you hear about our programs?

□ Newspaper □ Friend □ Radio □ Health Care Provider □ Poster/Flyer □ Other □ Mailing

Revised 2/24/14

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SEARHC Women's Health Programs

Annual Income Form-2014

I understand that the SEARHC Women's Health programs (BCHP and WISEWOMAN) are grant-funded and can only provide screening for breast and cervical cancer, heart disease, and stroke.

I understand that a Women's Health program screening consists of the following:

- Ages: 21 - 64: An office visit, including a clinical breast exam, pelvic exam, and Pap smear
- Ages: 30 - 64: The above, plus cholesterol and glucose blood tests, height, weight, blood pressure, and a health habits risk assessment.
- Ages: 40 - 64: The above, plus a mammogram.

I understand some specific follow-up diagnostic tests will be provided, if necessary, but the Women's Health programs cannot pay for complete diagnostic services or any treatment* or travel for treatment. If I need further testing, I agree to work with Women's Health staff for these services. Services covered by these grants are outlined in the Women's Health Covered Services cards.

I understand that if I am not a Native Beneficiary I will be billed for any services other than those defined above.

I understand I may drop out of the Women's Health program at any time.

I understand that in order to participate in these programs, my medical record will be made available to the SEARHC Women's Health staff for payment, quality control, and follow-up. These records will be held strictly confidential.

I understand that limited information, without my name, will be shared with the grant funding agency (CDC) on a confidential and as-needed basis, for program monitoring only.

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*The State of Alaska Medicaid Program enables women who are enrolled in the SEARHC Women's Health program and found to be in need of treatment for either breast or cervical cancer, or cervical dysplasia, to apply for treatment costs.

For Office Use Only:

Verified by PAR: _____ Date: _____ Screening Site: _____

□ WW and WHG entered into RPMS
□ WHG only entered into RPMS
□ AIF entered into RPMS
□ Beginning and End Eligibility Date