Eligibility Form
Every Woman's Life - Virginia Department of Health

PERSONAL INFORMATION

Last Name	First Name	MI	Maiden Name
SSN (or alien ID) / /	Birth Date / /	Age	
Address	City	County	
State	Zip	Home Phone ( ) -	
Work Phone ( ) -	Cell Phone ( ) -	Best Time to Call:	

What is your household income before taxes? $ /Year

How many people live on this income? (including yourself)

Do you have Medicaid? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No ➔If YES ☐Part A or ☐Part B

Private insurance? ☐ Yes ☐ No ➔If YES, has deductible been met? ☐ Yes ☐ No

QUESTIONS FOR NEW CLIENTS ONLY

How did you hear about the Every Woman's Life program? ☐ Brochure ☐ Community Health Worker ☐ Family/Friend ☐ Health Fair ☐ Internet/Web ☐Radio/TV/Newspaper ☐ Other

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

Do you describe yourself as: (check ALL that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/ Pacific Islander ☐ Unknown

What language do you speak every day?

Have you ever had a pap test? ☐Yes ☐ No
➔If YES, when was your last Pap test? (month/year) / or ☐ More than 5 years ago ☐ Don't know

Have you ever had a mammogram? ☐Yes ☐ No
➔If YES, when was your last mammogram? (month/year) / or ☐ More than 5 years ago ☐ Don't know

OFFICE USE ONLY

Administrative Site: ____Case Manager: _____________________________________
Enrollment Site: ____ Enrollment Date: _____ / _____/ _____
Client ID ____
Client Status: Active – check one: ☐ New Screen ☐ Rescreen ☐ Inactive due to:(list reason) _________________________
Effective Date _____ / _____/ _____
Detail: Previous Breast Cancer ☐ L Br ☐ R Br ☐Hysterectomy for Cervical Cancer ☐Hysterectomy Non Cancer
☐ **Cervical Record Only**, no breast form submitted ☐ **Breast Record Only**, no cervical form submitted