



**HEALTH SCREENING PROGRAM OF WASHINGTON
ENROLLMENT FORM (male colon screening only)**



NEW TO HSP PROGRAM? Yes No

NAME Last First MI			HSP PRIME CONTRACTOR		DATE (mm/dd/yyyy)
Previous Name			CLINICAL SCREENING SITE:		CHART NUMBER
DATE OF BIRTH (mm/dd/yyyy)		SOCIAL SECURITY NUMBER		APPOINTMENT DATE & TIME:	
ADDRESS			PROGRAM ELIGIBILITY (must be assessed annually) Household Income Before Taxes: \$ _____ <input type="checkbox"/> Annual <input type="checkbox"/> Monthly		
CITY		STATE		Number of People Who Live on This Income _____	
ZIP	COUNTY OF RESIDENCE		Insurance / Medical Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of insurance company or list medical coverage: _____		
HOME PHONE NUMBER ()		WORK PHONE NUMBER ()		Policy/Identification Number _____	
ALTERNATE CONTACT INFORMATION:			BEST TIME TO CALL: <input type="checkbox"/> AM <input type="checkbox"/> PM		MAY WE LEAVE A MESSAGE?

Colon Screening Eligibility: Screening age group is 50-64, and income is at or below 250% of the federal poverty level, and not on Medicaid or no private insurance (unless insurance coverage has a large deductible). Clients under 50 at high risk due to family history or over 65 and not on Medicare, may be eligible.

Note: If you have any of the following conditions, ulcerative colitis, Crohn's colitis, hereditary colon cancer syndromes such as HNPCC or are experiencing these symptoms, lower abdominal pain, bright red blood per rectum, marked change in bowel habits, bloody stools or unexplained weight loss you are not eligible for colon health services through the HSP.

Birth Country? USA Other (specify) _____

Are you Latina or Hispanic? (For example, Mexican-American, Puerto Rican, Cuban) Yes No

Primary Language? (select only one) English Vietnamese Korean Spanish
 Cambodian Russian Chinese Other (specify) _____

What race(s) are you? (Mark one or more race(s) to indicate what you consider yourself to be.)

White/Caucasian Native Hawaiian or Other Pacific Islander (specify) _____ Black or African-American
 Asian American Indian or Alaskan Native (specify Tribe/Nation) _____ Unknown

What is the highest grade of school you have completed? (number of school years) _____

If you are new to HSP, how did you learn about this program? (select only one)

- | | | | |
|---------------------------------------------|-------------------------------------------------|------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Self | <input type="checkbox"/> Employer | <input type="checkbox"/> TV | <input type="checkbox"/> Breast Cancer Prevention Fund |
| <input type="checkbox"/> Friend or Relative | <input type="checkbox"/> Handout | <input type="checkbox"/> Radio | <input type="checkbox"/> HSP Internet Website |
| <input type="checkbox"/> Community Group | <input type="checkbox"/> Religious Organization | <input type="checkbox"/> Poster | <input type="checkbox"/> Ask Me Campaign |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Mailing | <input type="checkbox"/> YWCA | |
| <input type="checkbox"/> Outreach Worker | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Other (specify) _____ | |

HSP Client Consent Form has been signed.