

**NECAC FAMILY PLANNING CENTER**

Name: \_\_\_\_\_ Birth date    /   /    SS#: \_\_\_\_\_  
mm/dd/yyyy (Optional)

Address \_\_\_\_\_  
Street City State Zip

The Missouri Department of Health and Senior Services invites you to take part in the Show Me Healthy Women Project (SMHW). If you qualify, you will receive your breast and cervical cancer examinations free. If your test results are not normal, this clinic will work with SMHW and/or Department of Social Services to help you obtain additional tests and, if needed, treatment.

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

Are you receiving: Unemployment insurance  WIC  TANF  Food stamps   
 Medicare Part A  and/or Part B  Medicaid  Have you applied for Medicaid

Do you have health insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your insurance have a deductible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Can you pay the deductible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your health insurance an HMO?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**CLIENT AGREEMENT**

I have not supplied documentation of household income. I declare my household income is within SMHW present income guidelines. \_\_\_\_\_ (If applicable, please initial)

I have received the income guidelines and I qualify for the SMHW.

A staff person has informed me which tests the SMHW program covers.

I understand that the SMHW 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 need to contact this clinic for my test results.

I understand that no test is 100% accurate.

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 by SMHW, 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 the Client/Guardian/  
 Durable Power of Attorney for Health Care (DPOA-HC)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date