WEST VIRGINIA WISEWOMAN
Client Enrollment

Internal Use Only

Date : _____ Provider Name :_____

WVBCCSP Enrollment Facility: _____ WVBCCSP # _____

Demographic Information

First Name: _____ M.I. ___ Last Name: _____ Date of Birth: _____

Gender: ☐ Female ☐ Transgender Male ☐ Transgender Female SSN#: _____

Address: _____ City: _____ State: _____ Zip: _____ County:_____

What is your highest level of education?
☐ Less than 9th grade ☐ Some high school ☐ High school graduate or equivalent ☐ Some college or higher

Day Phone: (_____) _____ Evening Phone: (_____) _____ Email Address: _____

Ethnicity: Are you of Spanish or Hispanic origin, such as Mexican American, Latin American, Puero Rican or Cuban?
☐ Yes ☐ No ☐Unknown

Race(s): What race do you primarily identify with? (check one) ☐ Black or African American ☐ White
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Unknown

Race(s): What other race do you identify with? (check one) ☐ Black or African American ☐ White
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Unknown

Race(s): Do you identify with any other races? (check all that apply) ☐ Black or African American ☐ White
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Unknown

What is your primary language spoken at home? ☐ English ☐ Spanish ☐ Arabic ☐ Chinese ☐ French ☐ Italian ☐ Japanese ☐ Korean ☐ Polish ☐ Russian ☐ Tagalog ☐ Vietnamese ☐ Creole ☐ Portuguese ☐ Hmong ☐ Other (write in) _____

Need Interpreter at the appointment? ☐ Yes ☐ No Living with a disability? ☐ Yes ☐ No

Insurance Status:
Medicaid: ☐ Yes ☐ No
Medicare Part B: ☐ Yes ☐ No
Other Insurance (specify insurance): _____
Underinsured: ☐ Yes ☐ No
Ref to Insurance: ☐ Yes ☐ No
Date ref. to insurance (mm/dd/yy): _____

Income Eligible ☐ Yes ☐ No

Household Annual Income $_____

Household Size (includes yourself, if married your spouse and dependant children):