WAYNE COUNTY HEALTH CENTER
115 HICKORY STREET
PO BOX 259
GREENVILLE MO 63944
PHONE: (573) 224-3218 FAX: (573) 224-3164

Public Health
Prevent. Promote. Protect.

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 ☐ No☐
Does your insurance have a deductible?	Yes ☐ No ☐
Can you pay the deductible?	Yes ☐ No☐
Is your health insurance an HMO?	Yes ☐ No ☐

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/ Date
Durable Power of Attorney for Health Care (DPOA-HC)