

Community Based Venue

Initial Encounter Assessment
CLIENT INFORMATION

Client Information

First Name _____ Last Name _____
 Address _____
 State Phone: L _____ Call Phone: L _____
 Email address _____
 Date of Birth: ____/____/____ Gender: (2 Male 3 Female) Hispanic: (1 Yes 2 No)
 Race/Ethnicity: (Spanish 2 Greek 3 German 4 Other) (Select one) (2 Male 3 Female)

Are you insured or are you in any waiting period of coverage? (1 Yes 2 No) (Select one)
 Do you have any health problems that require you to see a doctor, nurse or other health professional? (1 Yes 2 No) (Select one)
 If yes, what type of disability? _____
 Are you a caregiver? (1 Yes 2 No) (Select one)
 If yes, what type of caregiver? _____
 Country of Residence in Nebraska _____
 Are you a Nebraska resident? (1 Yes 2 No) (Select one)
 Do you have health insurance? (1 Yes 2 No) (Select one)
 If yes, what type of insurance? (1 Medicare 2 Medicaid 3 Private 4 Other) (Select one)
 Do you have any medical conditions prescribed by your doctor? (1 Yes 2 No) (Select one)
 If yes, what type of medical conditions? _____
 Do you take any medications prescribed by your doctor? (1 Yes 2 No) (Select one)
 If yes, what type of medications? _____

Initial Assessment (14 questions)
ALL assessments are entered into ENCOUNTER

- Assess Insurance Status
- Health History
- Nebraska Residency

- MARK:** Client enrolling in EWM
- MARK:** Client Enrolling in NCP

- MARK:** Client Marked for Navigation in Encounter
- MARK:** Client Marked for Health Coaching in Encounter

-Client does not have insurance
 -Age 40-64 (breast/cervical) or 50-64 (colon)
 -Nebraska Resident or Legal Alien
 -In Need of breast and/or cervical or colon services

Client **NOT** eligible for Every Woman Matters

Refer to EWM
 -Client to fill out Healthy Lifestyle Questionnaire

Healthy Lifestyle Questionnaire

Please fill out this form. Filling out this form will help Every Woman Matters (EWM) and the Nebraska Colon Cancer Screening Program (NCCSP) determine what services are best for you.

Even if you are not able to get services, you can still get health education.

WHAT YOU NEED TO KNOW:

You must **BE** have health insurance that would pay for preventive services.
 Please answer **ALL** questions. If you don't see we will call you or send the form back to you and the **code** doing important health screenings.
 Please **PRINT** clearly. Use a **black** ballpoint pen. Do not use pencil.
 This is **NOT** your screening card. Please do **NOT** make an appointment with your health care provider until you get a screening card.

Thank you for taking time for your health!

Client **becomes** an **Every Woman Matters Client**
(documentation in MED-IT)

Client **remains** a **Community Based Client**
(documentation in ENCOUNTER)