



A Service of the Try-To-Stop Smokers' Helpline

In Collaboration with the Massachusetts Department of Public Health and Massachusetts Health Plans



Homecare

ILC

Patient Stamp, Label or Info (Name, Record Number/DOB, Date)

- If a patient is interested in quitting smoking, fill out this form with them.
- Fax completed form to 1-866-560-9113.
- The Try-To-Stop Smokers' Quitline will contact the patient, offer free cessation services and send feedback reports to the provider listed below.
- This program is free for all Massachusetts residents regardless of insurance status

Massachusetts Enrollment Form

Tobacco users can also call 1-800-Try-To-Stop (1-800-879-8678) to receive services

Patients: Complete this section

First Name _____		Last Name _____		Are you 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address _____ ()			City _____	State _____	Zip _____
Phone Number _____					
When should we call? (check all that apply) <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> No preference					
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____					
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Primary Insurance of Tobacco User: <input type="checkbox"/> Blue Cross Blue Shield MA <input type="checkbox"/> Tufts Health Plan <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> MassHealth/Medicaid <input type="checkbox"/> Other <input type="checkbox"/> None					
I authorize this provider to release the information on this enrollment form to QuitWorks so that I may be contacted and participate in the QuitWorks program. I also authorize QuitWorks to disclose information about my progress in attempting to quit smoking to the health care provider listed on this form.					
Patient Signature _____				Date _____	

Health Care Providers: Complete this section

Referring Provider: _____	Phone Number () _____
Facility: _____	Fax Number () _____
Address: _____	
Send feedback report to:	
<input type="checkbox"/> Same as above or	Betty Maher, Homecare Assistance (617) 727-2809 (617) 204-3853
Name _____	Phone Number _____ Fax Number _____
PEDIATRICS ONLY:	
Patient's relationship to child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____	
Child/Children's name: (to help with recordkeeping) _____	

Copies of this form can be downloaded from WWW.QUITWORKS.ORG

Fax this form toll-free to 1-866-560-9113



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Formulario de inscripción de Massachusetts

Las personas que usan tabaco también pueden llamar al 1-800-879-8678 para recibir servicios.

La persona que usa tabaco debe completar la siguiente sección:

Nombre _____		Apellido _____		¿Tiene 18 años de edad o más? <input type="checkbox"/> Sí <input type="checkbox"/> No	
Dirección postal _____ ()		Ciudad _____		Estado _____	Código postal _____
Número de teléfono _____					
¿Cuándo prefiere que llamemos? (marque todo lo que corresponda) <input type="checkbox"/> Mañana <input type="checkbox"/> Tarde <input type="checkbox"/> Noche <input type="checkbox"/> Ninguna preferencia					
Preferencia de idioma: <input type="checkbox"/> Inglés <input type="checkbox"/> Español <input type="checkbox"/> Otro (especificar) _____					
¿Podemos dejar un mensaje? <input type="checkbox"/> Sí <input type="checkbox"/> No					
Seguro principal de la persona que usa tabaco: <input type="checkbox"/> Blue Cross Blue Shield MA <input type="checkbox"/> Tufts Health Plan <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> MassHealth/Medicaid <input type="checkbox"/> Otro <input type="checkbox"/> Ninguno					
Autorizo a este proveedor de servicios de salud a dar la información de este formulario de inscripción a QuitWorks para que puedan contactarme y pueda participar en el programa QuitWorks. También autorizo a QuitWorks a dar información sobre mi progreso en el intento de dejar de fumar al proveedor de servicios de salud nombrado en este formulario.					
Firma de la persona que usa tabaco _____				Fecha _____	

Los proveedores de servicios de salud completarán esta sección (Health care providers complete this section):

Referring Provider: _____	Phone Number _____ ()	
Facility: _____	Fax Number _____ ()	
Address: _____		
Send feedback report to:		
<input type="checkbox"/> Same as above or Betty Maher, Homecare Assistance	(617) 727-2809	(617) 204-3853
Name	Phone Number	Fax Number
PEDIATRICS ONLY:		
Patient's relationship to child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____		
Child/Children's name: (to help with recordkeeping) _____		

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