Orange Flag Building, 104 S Freya, Suite 114 l Spokane WA 99202 l (509) 532-8877 l Fax (509) 532-1375

Project Access Enrollment Information

Thank you for inquiring about Project Access, a program of the Spokane County Medical Society Foundation. Project Access is a non-profit organization that coordinates volunteered medical services to qualified low income, uninsured residents of Spokane County. To qualify for Project Access, you must:

1. **Be a current Spokane County Resident for at least 90 days.**
2. **Not be currently receiving Medicaid, Medicare or be covered by any other health insurance.**
3. **Earn a gross household income of less than 200% of the Federal Income Guidelines**
4. **You must have a current referral from a Primary Care Provider for the medical specialty service your doctor requires.**

Enclosed are copies of the enrollment form, release of information and self employment reporting form.

If you have questions about this application or your qualifications for Project Access, please call (509) 532-8877 and ask to speak with an enrollment specialist.

To apply for Project Access services, please:

- ☐ Completely fill out and sign the enclosed application.
- ☐ Supply required information and return them by fax or mail (above).

Please check-off items as you enclose the following required documentation:

- ☐ Completed and signed application
- ☐ Proof of identification – Current state-issued drivers license, state identification card or passport
- ☐ Proof of residency in Spokane County – A utility bill or lease agreement in your name. If you live with a friend or relative, a utility bill or lease agreement in the name of the person with whom you reside along with a written statement of your residence with their signature and contact information will be sufficient for proof of residency.
- ☐ Current bank statements for the past 90 days (if claiming no income)
- ☐ Current income documents – gross household from all sources of income for the past 30 days
- ☐ If self-employed – last 90 days of personal and business bank statements, last year’s tax return and completed self-employment reporting form (included in application packet)
- ☐ Release of Information SIGNED (both top and bottom)

★ **Please note: It is required that you apply for DSHS medical coverage when applying to the Project Access program.** ★

Project Access may contact you for additional information regarding your application.
Your application will be processed in a timely manner.

Project Access Spokane

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Enrollment Form

Project Access coordinates volunteer medical services for qualified low income, uninsured residents of Spokane County

PATIENT INFORMATION

First Name:		Last Name:	
Gender: ☐ Male ☐ Female	Social Security Number:	Date of Birth:	Employer Name:
Marital status: ☐ Married ☐ Separated ☐ Single	Best number to reach you (day): Circle one: Home Work Cell Message		Other phone number: Circle one: Home Work Cell Message
Physical Address:			Physical City / Zip:
Mailing Address:			Mailing City / Zip:
Are you a current resident of Spokane County? ☐ No ☐ Yes—how long?____________________		Race / Ethnicity	Do you need an interpreter? ☐ No ☐ Yes Language: ____________________

PLEASE INCLUDE WITH YOUR APPLICATION MATERIALS

- **As proof of identification,** please provide a current government-issued ID, such as a driver's license, state-issued ID card or passport.
- **As proof of residency**, please provide one of the following documents: Electricity or water bill in your name (full page of last bill issued) or lease agreement (your current agreement, signed, dated)
- **Are you currently homeless?** ☐ **No** ☐ **Yes** – Please provide a letter from a shelter to verify your current status to verify residency or explain your situation on the Circumstance Declaration Form.
- **Are you currently living with a friend or relative?** ☐ **No** ☐ **Yes** – Please provide a letter from the person with whom you are residing and a utility bill or lease agreement in their name to verify residency

HEALTH INFORMATION

Referring Clinic: ☐ **CHAS** ☐ **SFFC / Riverstone** ☐ **Christ Clinic** ☐ **Native Health** ☐ **Other:** ______________________________

Primary Care Provider: ____ ☐ I am applying to receive Primary Care

Have you been to an Emergency Room in the past twelve months? ☐ No ☐ Yes – Month/Year: ______________________________

☐ Sacred Heart ☐ Holy Family ☐ Deaconess ☐ Valley ☐ Other: **Hospital name** _________________ **City/State** __________________

MEDICAL BENEFIT INFORMATION

Do you have a Provider One medical card (Medicaid)? ☐ No ☐ Yes
Do you have a spend-down amount? ☐ No ☐ Yes – Amount: ______________
Do you have Medicare? ☐ No ☐ Yes

Have you applied for: Medicare? ☐ No ☐ Yes – Date applied: ___________ **Medicaid?** ☐ No ☐ Yes – Date applied: ___________

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Do you currently have medical insurance?
☐ No ☐ Yes – Insurance Co. __________________________ Group # _________________ Policy # ____________

Is the medical care you need a result of an on-the-job injury, car accident or injury caused by another? ☐ No ☐ Yes—please explain:

____

HOUSEHOLD INFORMATION

List yourself, your spouse and legal *dependent children.* (*Legal dependants include only children under 18 years of age, who live with you and the IRS deem legal dependants. Roommates, significant others and parents living with you need not be included in your household.)*

Total number of people _________

PLEASE LIST those in your household who fit above criteria including yourself:

Name	Self	Age	Name	Relationship	Age
Name	Relationship	Age	Name	Relationship	Age
Name	Relationship	Age	Name	Relationship	Age

FINANCIAL INFORMATION

To qualify for Project Access, your gross household income must be less than 200% of the Federal Income Guidelines:

Family of 1 = $21,780 / $1815 monthly
Family of 2 = $29,420 / $2451 monthly
Family of 3 = $37,060 / $3088 monthly
Family of 4 = $44,700 / $3725 monthly
Family of 5 = $52,340 / $4361 monthly
Family of 6 = $59,980 / $4998 monthly

What is the GROSS monthly combined income (*before* taxes and other deductions) of your household?

Total monthly income $____________

Please include proof of income from ALL income sources in your household

Does your household currently have more than $15,000 (combined) in checking and savings? ☐ **No** ☐ **Yes**

Please indicate all sources of income you and your spouse receive. Check all that apply to your household. (Proof from all sources of income will need to be provided with this application)

- ☐ I receive income from **Employment**. Provide all pay stubs from you and your spouse for the last 30 days
- ☐ I receive income from **SELF-EMPLOYMENT including income from rental property and investments**. Complete Self-Employment Income Reporting Form reporting on the last 90 days and included the last 90 days of bank statements for both personal and business accounts
- ☐ I receive income from the following:
  - ☐ Unemployment
  - ☐ SSI / Disability
  - ☐ Other:____
- ☐ I currently have no income. Please explain how you meet your basic needs such as food, clothing, shelter and utilities on the Circumstance Declaration Form. **Include 90 days of bank statements with your application materials.**

Is your household receiving food assistance? ☐ No ☐ Yes – Please provide a current food assistance award letter

Monthly food stamp amount: ______________ Number of people receiving assistance in your household _________

Circumstance Declaration Form

Living Expenses

Rent / Mortgage amount: ______________________

Monthly Utilities: ______________________

Groceries: ______________________

Student Loans: ______________________

Car Payment: ______________________

Child Support: ______________________

Charge Accounts: ______________________

Other: ______________________

Monthly Income

Employment Income: ______________________

Unemployment: ______________________

Other Income: ______________________

Checking Account Balance: ______________________

Spouse Employment Income: ______________________

Social Security / Disability: ______________________

Other Income: ______________________

Savings Account Balance: ______________________

Statement of Circumstance

Living Situation / How I pay rent: ______________________

____

____

____

Financial Situation / How I pay bills: ______________________

____

____

____

Other Circumstances / Assistance from Friends and Family: ______________________

____

____

____

I do not have the following documentation requested in this application: ______________________

Reason I do not have documentation: ______________________

____

____

I hereby certify that all application materials in addition to the above circumstance declaration information is true and complete.
I understand that by supplying false information I will be held responsible for 100% of my medical expenses.

____
Signature

____
Date

____
Print name

AGREEMENT

<u>You agree that you will **(read carefully—these are requirements of the Project Access program)**:</u>

- Work with your assigned Project Access Patient Care Coordinator, who will schedule **ALL** of your referral medical appointments or hospital visits.
- Follow your treatment plan: (i.e.: fill prescriptions and take medications as prescribed by specialist).
- Promptly supply any additional information Project Access requests.
- Allow your information to be shared with other individuals and agencies solely at the discretion of Project Access.
- Immediately contact Project Access if your address, phone number, marital status, or income changes, as well as, if you become eligible for medical insurance, Medicare, Medicaid or other health care assistance.
- Apply for other assistance at Project Access' request.
- Keep each appointment. If you miss any appointments without 24 hours notice, you may be dismissed from the program.

<u>You understand that:</u>

- Providing false or misleading information on this application or in supporting documents may result in immediate disqualification from Project Access.
- Patients who anticipate or are currently seeking legal action regarding their injury or illness are not eligible.
- If you miss a scheduled appointment without notifying Project Access and the doctor's office, you will be dismissed from the program.
- Emergency room, ambulance services, past medical bills and **medical appointments you arrange on your own** are not covered by Project Access.
- All medical appointments are donated and our ability to provide medical appointments and services is not guaranteed. Our inability to provide a donated medical service is not a determination of your medical need.
- Prescriptions services provided through Project Access are for those medications prescribed by the specialist, not your everyday medications.

<u>You Certify That</u>:

- You have lived in Spokane County for at least 90 days,
- Your income fits Project Access guidelines
- You do not have health care insurance.
- The information you have given is accurate and complete to the best of your knowledge.
- You have enclosed all supporting documents required for enrollment qualification:
  - ⇒ Completed and signed application
  - ⇒ Proof of identification – Current state-issued drivers license, state identification card or passport
  - ⇒ Proof of residency in Spokane County – A utility bill or lease agreement in your name. If you live with a friend or relative, a utility bill or lease agreement in the name of the person with whom you reside along with a written statement of your residence with their signature and contact information will be sufficient for proof of residency.
  - ⇒ Current bank statements for the past 90 days (if claiming no income)
  - ⇒ Current income documents: Gross household from all sources of income for the last 30 days or
    If self- employed – last 90 days of personal and business bank statements, last year's tax return and self-employment reporting form (included in application packet)
  - ⇒ Release of Information SIGNED (both top and bottom)

★ **Please note: It is required that you apply for DSHS medical coverage when applying to the Project Access program** ★

______________________________ ______________________________

Signature Date

____

Print name

AUTHORIZATION TO SHARE / COLLECT INFORMATION

I, ______________________________, Date of Birth ___/___/_____, allow my doctor(s) and or any other health care providers to give medical information relating to my use or need of the Project Access program and their services. This information can include spoken or written facts about my health and payment and or benefits. It can include copies of records from any or all of my health care providers. In addition, I authorize **Department of Social and Health Services (DSHS)**, **Health For All or any other entity** to exchange my personal information with Project Access, and Project Access to provide DSHS, Health For All, or any other entity my personal information. This information can include spoken or written facts about my health, payments, financial information and or benefits. It can include copies of records that I have provided to either entity. This permission will continue as long as I am enrolled in Project Access unless I notify Project Access, Basic Health of Washington and DSHS.

I also authorize Project Access to disclose pertinent information to other agencies or firms, as may be necessary, for the sole purpose of obtaining a standard credit report on the undersigned, including investigations of personal credit history, employment and other financial situations. I understand that the information obtained will be treated as totally confidential and that NO information on the report will be accessible to any party not directly involved.

Project Access will only use and give out this information to see if I qualify for the Project Access program and to administer their program. People that work for and with Project Access may also see my information, but they may use it only to help me get assistance with medical care, pharmaceuticals, durable medical equipment and data collection. I understand that they will make every effort to keep my information private and confidential, but if it is accidentally given out, federal privacy laws are waived.

This authorization will last until I am no longer participating in the Project Access program. If I change my mind before that time, I will notify in writing the Project Access Director, my health care providers and physician (s) that I do not want them to share any additional information with Project Access. However, this will not change any actions that were taken before I advised them of my change of mind. I know that I have a right to see or request, for a nominal fee, a copy of the information that is contained in my Project Access working file. I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. If I refuse to sign this form, I know that it means that I may not be able to participate in the Project Access Program.

____________________________________ ____________________________

Signature Date

____

Print name

Self-Employment Income Reporting Form

Complete this form only if you have self-employment income

Along with this completed form you must enclose (copies only – originals will not be returned)
- ☐ A copy of your most recent business and personal tax return(s)
- ☐ The most recent 90 days business and personal bank statements

Business Name: ____

Name(s) of business owners: ____

Washington State UBI# ____ Check box if no UBI# ☐

Name of Project Access Applicant: ____Birth Date: _________

Date business began: __________________________ Total number of months in business: ________________________

Type of business: ☐ Rentals ☐ C-Corporation ☐ LLC ☐ Sole Proprietor ☐ S-Corporation ☐ Partnership ☐ Not incorporated

Percentage of business owned by you and/or your spouse: ____________________

Months you are reporting (**most recent 3 months**): From __________________ through ___________________
Month / Year Month / Year

Income *(Gross receipts, sales or rental income total for this three-month period)* ____________________________

Business related expenses *(for three-month period)*

Merchandise and materials	______________________
Gross wages paid to employees (less employment credits)	______________________
Employer's payroll-related taxes/benefits	______________________
Advertising / other promotional	______________________
Car and truck	______________________
Commissions / management fees	______________________
Insurance	______________________
Interest – Other	______________________
Interest – Mortgage	______________________
Legal and professional fees	______________________
Rent or lease of vehicles, machinery, equipment	______________________
Rent or lease of other business property	______________________
Repairs and maintenance	______________________
Supplies	______________________
Taxes and licenses	______________________
Travel, meals and entertainment	______________________
Utilities	______________________
Other: ________________________________	______________________

Total Business Expenses *(for three-month period)* ______________________

Total Net Profit (or Loss) *(for three-month period)* ______________________