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

Project Access Enrollment Form

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

PATIENT INFORMATION

First Name:		**Last Name:**	
☐ **Male** ☐ **Female**	**Social Security Number:**	**Date of Birth:**	**Employer Name (if you work):**
Are you married? ☐ Yes ☐ No	**Best phone number to reach you (day):**		**Other phone number:**
Address:			**What language do you speak?**
City, State, Zip:			**Race/Ethnicity:**
Are you currently a resident of Spokane County? ☐ Yes – for how long? _____ ☐ No			**Do you need an interpreter?** ☐ Yes ☐ No

As proof of residency, please provide a copy of one of the following (that has the same name/address as above) check *one*:

☐ WA State Drivers license or identification card ☐ utility bill ☐ lease agreement ☐ school registration
☐ or utility bill or lease from person you live with, along with their confirmation of your residence and their signature

HEALTH INFORMATION

What is the name of the medical office where you receive your health care? (Please circle one)

CHAS (list branch):_____ Spokane Falls Family Clinic NATIVE Health Christ Clinic Other (List)_____

Who is your primary care provider?_____

MEDICAL BENEFIT INFORMATION

Do you have a medical coupon (Medicaid)? ☐ Yes ☐ No Do you have a spend down amount? ☐ Yes ☐ No
Do you have Medicare? ☐ Yes ☐ No

Have you applied for:

Medicare?	☐ Yes	☐ No	
Medicaid?	☐ Yes	☐ No	
Basic Health Plan of WA	☐ Yes	☐ No	☐Waiting List

Do you currently have medical insurance?
☐ Yes, Insurance Co. _____ Group # _____ Policy # _____
☐ No

Does your employer offer medical Insurance?
☐ Yes – Please explain why you are not covered? _____
☐ No

Is the medical care you need a result of an on-the-job injury, car accident or injury caused by another?

☐ Yes - Please explain:_____
☐ No

FINANCIAL INFORMATION

How many people live in your house full-time and are supported by the household income, including yourself, your spouse and legal *dependents?* Total number of people : _____

PLEASE LIST BELOW those that fit above criteria including yourself:

Name	Self	Age	Name	Relationship	Age

Name	Relationship	Age	Name	Relationship	Age

Name	Relationship	Age	Name	Relationship	Age

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

$_____/total per month.

Proof of income is required for all members in the household.

A. Does your household currently have more than $5,000 (combined) in checking and savings? ☐ Yes ☐ No

B. Does your household have any income (you or your spouse)?

☐ Yes, from Employment (Provide pay stubs from the last 30 days for your household**)**

☐ Yes, from **SELF-EMPLOYMENT—**(Complete Self-Employment Income Reporting Form and include requested bank statements)

☐ Yes, from the following (Provide benefit statements for the last 30 days for your household)**:**

_____Spousal Support / child support / adoption/foster child support

_____ Pension/Tribal benefits/school grants award letter (not loans)

_____ Unemployment, Worker's Compensation, Social Security or disability benefit

_____ Another form of income _____

☐ *No, this doesn't apply to me* - Please explain how you meet your basic needs such as food, clothing, shelter and utilities. If more space is required please attach an additional page with your statement. (Please **include a letter** from the shelter or third party, (relative, friend) that provides these basic needs.)

_____

_____

_____

C. Is your household receiving Food Stamps?

☐ *No, this doesn't apply to me*

☐ *Yes* – Please provide a copy of current award letter

D. Are you currently homeless?

☐ *No, this doesn't apply to me*

☐ *Yes* – (If applicable, please provide a letter from a shelter, service agency or person that can verify this.)

E. Is there any more information about your financial situation you would like Project Access to know?_____

_____

AGREEMENT AND SIGNATURE

You agree that you will **(read carefully-these are requirements that you are agreeing to)**:

- Work with your assigned Project Access - Patient Care Coordinator, who will schedule your referral medical appointments or hospital visits.
- Follow your treatment plan: (i.e.: fill prescriptions and take medications as directed).
- Promptly supply any 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 income changes or you become eligible for medical insurance, Medicare, Medicaid, or other health care assistance.
- Apply for other assistance at Project Access' request.
- Contact Project Access if you have a change in address or phone number.
- You must contact Health for All referral program at (509) 444-3066 for resources and insurance.
- If you have not already applied for the Basic Health Plan of WA you must contact them to apply Or, be put on the waitlist 1-800-660-9840.
- Keep each appointment. If you miss any appointments without 24 hours notice, you may be dismissed from the program.

You understand that:

- Patients who anticipate 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, it is at the discretion of the provider whether they will reschedule your appointment.
- If you need transportation, you may contact your Care Coordinator who will arrange for it.
- Emergency room and ambulance services are not covered.
- Durable medical equipment must be pre-authorized.

You Certify That:

- You live in Spokane County.
- The information you have given is accurate and complete to the best of your knowledge.

_____ _____

Signature Date

IMPORTANT! YOU MUST INCLUDE ALL REQUESTED DOCUMENTS WITH THIS FORM

- PROOF OF INCOME DOCUMENTS
- PROOF OF RESIDENCY DOCUMENTS

YOUR ENROLLMENT FORM WILL NOT BE PROCESSED WITHOUT THESE DOCUMENTS