



PROJECT ACCESS MULTNOMAH COUNTY ENROLLMENT / RE-ENROLLMENT FORM

PAGE 2 – ELIGIBILITY CHECKLIST

LAST NAME	FIRST NAME	MI	HOME CLINIC:

Check ALL that APPLY

I do not have health insurance (employer or private based insurance) Medicaid/OHP, Medicare, US Military, COBRA, or SSDI. I am not covered by a spouse, domestic partner, parent or school.

I am at or below 200% of the 2009 Federal Poverty Level:

Household	Monthly Gross Income	Household	Monthly Gross Income
1 person	\$1,809	5 people	\$4,309
2 people	\$2,434	6 people	\$4,933
3 people	\$3,059	7 people	\$5,558
4 people	\$3,684	8 people	\$6,183

I do not need to see a medical specialist because of a pending law suit related to a Motor Vehicle Accident (MVA), work (Worker’s Compensation), or pending lawsuit (slip and fall).

I am not currently pregnant.

I have never been given a diagnosis of End Stage Renal Disease (ESRD). I have not had a kidney transplant.

I have never been given a diagnosis of End Stage Liver Disease (ESLD). I have not had a liver transplant.

I do not suspect I may have breast or cervical cancer (you may qualify for the Oregon Breast and Cervical Cancer Program).

SUPPLEMENTAL CHECKLIST

Medicaid/ OHP:

Applied Date: _____

Denied Date: _____ Reason: _____

Lost coverage Date: _____ Reason: _____

Disability:

Applied Date: _____

Denied Date: _____ Reason: _____

COBRA:

Eligible Date: _____ Premium Amount: \$ _____

Project Access does not provide health care services. We provide medical referrals to participating volunteer providers. These referrals are limited by the availability of volunteers in any area of specialty or geography. Project Access cannot guarantee services.



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PAGE 3 – ENROLLMENT INFORMATION

LAST NAME		FIRST NAME		MI	DATE OF BIRTH
STREET ADDRESS		CITY	STATE	ZIP	TELEPHONE HOME
MAILING ADDRESS (if different from above)		CITY	STATE	ZIP	TELEPHONE WORK
GENDER M F Transgender	RACE/ETHNICITY (optional)	Preferred Language Spoken:	Interpretation Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		CELL or MESSAGE
Number in Household:	DRIVER LIC/STATE ID #: _____ State:	<u>Applicants Employment:</u> <input type="checkbox"/> Full time <input type="checkbox"/> Seasonal Work <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Temporary <input type="checkbox"/> Other:			HOME CLINIC PAMC# (previously enrolled)

HOUSING AND EMPLOYMENT INFORMATION

Please list everyone in your household earning income. You must include gross (pretax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, etc.

Name	Relationship to Patient	Name of Employer/Source of Income	Monthly Gross Income
1.			\$
2.			\$
3.			\$
4.			\$
5.			\$
6.			\$

ADDITIONAL INCOME AND EXPENSE SUPPORT

Check ALL that APPLY:

<input type="checkbox"/> Food Stamps	<input type="checkbox"/> VA Benefits	<input type="checkbox"/> Lottery
<input type="checkbox"/> WIC	<input type="checkbox"/> Inheritance	<input type="checkbox"/> Small Loans from Family/Friends
<input type="checkbox"/> Social Security Income	<input type="checkbox"/> Legal Settlement	<input type="checkbox"/> Shelter and Social Services
<input type="checkbox"/> Disability	<input type="checkbox"/> Spousal Support	<input type="checkbox"/> No Income (<i>must fill out Attachment A</i>)
	<input type="checkbox"/> Child Support	<input type="checkbox"/> Other:

ASSET INFORMATION (FILL OUT ONLY IF ASSETS ARE OVER \$75,000)

<input type="checkbox"/> Real estate, other than primary home \$ _____	<input type="checkbox"/> Stocks/Bonds/CD's etc. \$ _____
<input type="checkbox"/> Vehicle, other than primary car \$ _____	<input type="checkbox"/> Other assets: _____ \$ _____

I certify that this information is a full and complete disclosure of my income and address(s). I certify that the above information is true to the best of my knowledge and there is no intent to commit fraud. I understand that appropriate action will be taken if the above information is misrepresented; including a bill for the services received. I agree to a credit check to confirm my information.

Signature: _____ **Date:** _____

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PAGE 4 – PATIENT AGREEMENT - RIGHTS & RESPONSIBILITIES

Patient Rights

1. I have the right to privacy. My privacy will be protected as outlined in the Notices of Privacy Practices, which I will receive in the mail, with my orientation packet.
 (<http://www.projectaccessnow.org/viewattachment.php?id=393>)
2. I have the right to receive all information, in plain language, about my medical care.
3. I have the right to ask questions and discuss concerns about my health.
4. I have the right to discuss my personal and cultural beliefs with my doctor when making decisions about my medical care.
5. I have the right to feel safe and receive respectful treatment by doctors, clinics and Project Access.
6. I have the right to discuss concerns about respectful treatment, safety and other program issues with **Project Access at 503-517-2005.**

Patient Responsibilities

1. I will call **my referral coordinator at my home clinic** to confirm all of my scheduled appointments 3 business days beforehand. If I do not confirm my appointment, I understand it will be canceled.
2. After every appointment, I will call **my referral coordinator at my home clinic** to talk about next steps.
3. I will arrive 15 minutes before my scheduled appointment.
4. If I miss my appointment after saying I would be there, I understand I may be ineligible for Project Access for at least six months.
5. I will follow medical advice and cooperate with my providers and care coordinators.
6. I will bring my Project Access card to every appointment.
7. I will direct all non-medical concerns to Project Access, not to the volunteer provider’s office.
8. I will provide accurate information and inform Project Access of any changes in my information, such as living situation, phone number, employment status, etc.
9. If interpretive services are not available, I will bring an English-speaking adult (18 years or older) to my appointment.
10. I understand my Providers are volunteers who are not being paid for their services, and that this is not a government service or insurance program. If I receive a bill for services not included in Project Access, I will call the office at **503 – 517 – 2005**, to assist me in seeking a full discount.

As a Project Access patient, I understand I am receiving free services from volunteer doctors. I agree to follow these detailed responsibilities. I understand that Project Access is not insurance and I am not guaranteed any services.



Signature: _____

Date: _____

**Please make sure that all of the pages are filled out, signed and dated.
 Return your application and copies to:**

at:

 Referral Coordinator

 Home Clinic

