CHAMPIONS for HEALTH | PHYSICIANS IMPROVING HEALTH CHANGING LIVES

Project Access San Diego

Please include the following with your application:

- **Proof of identification**
  - A picture ID issued by the government (ie. drivers license, passport, state ID, etc.)
- **Proof of residence in San Diego County**
  - Include one of the following documents: water/light/phone bill under your name or lease agreement (current, signed, and dated)
    - *Are you homeless?:* Include a written letter from the shelter where you are staying.
    - *Are you living with a friend or relative?*: Include a written letter from the person you are living with along with a bill or lease agreement under their name.
- **Proof of Income**
  - Include paystubs from you and your spouse (if applicable) from the last 30 days
    - *I receive unemployment:* Include proof of unemployment.
    - *I am self-employed:* Submit a copy of your most recent taxes including the form Schedule C and the form "Declaration of profit and loss."
    - *Are you receiving food stamps or other help?*: Include CalFresh Notice of Action that indicates the amount you are given each month.
    - *I do not have an income:* Write a letter explaining how you cover the basic costs of living. Include a letter written by the person who help you financially.
  - Include your bank statements from the last 30 days if applicable. If you do not have a bank account, please indicate this on your application or in your letter.
- **Notice of Action from public assistance programs that you have applied for** (CMS, Medi-Cal, LLIHP, Medicare)

CHAMPIONS for HEALTH

Project Access San Diego
Patient Enrollment Application

PATIENT INFORMATION

First Name:		Last Name:	
Gender: ☐ Male ☐ Female	Social Security #:	Date of Birth:	Email:
Marital Status:	Phone number: Home: Cell:		Is it okay if we send text messages?:
Address:			Zip Code:
Are you a current San Diego resident? ☐ No ☐ Yes	Race/ethnicity:		Preferred language:
Religion: ☐ None ☐ Jehovah's Witness ☐ Catholic ☐ Muslim ☐ Christian ☐ Other _____	Education: ☐ Less than high school ☐ GED ☐ High school diploma ☐ College or higher		Employment Status: ☐ Seasonal ☐ Student ☐ Disabled ☐ Unemployed ☐ Retired ☐ Full time ☐ Part time

Emergency Contact Information:

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship: _____

PATIENT HEALTH HISTORY

☐ Anemia	☐ Diabetes	☐ Kidney Disease
☐ Anticoagulation	☐ Diarrhea	☐ Liver Disease
☐ Arthritis	☐ Eye Disease	☐ Major Blood Vessel Disease
☐ Asthma/COPD	☐ Epilepsy	☐ Mental Illness
☐ Bleeding	☐ GERD	☐ Migraines
☐ Bowel Disease	☐ Gout	☐ Multiple Sclerosis or Nerve Disorder
☐ Claustrophobia	☐ Hyperlipidemia	☐ Obesity

1. In the last 6 months, how many times have you been to the emergency room? ____
2. Which emergency room/s? _____
3. In the last 6 months, how many nights have you been hospitalized? ____
4. In the last 6 months, how many times have you gone to you gone to your home clinic? ____
5. In the last 30 days, how many days have you had symptoms of the condition for which you are being referred? ____
6. In the last 30 days, how many days have symptoms from this condition kept you from working/caring for your family? ____
7. You overall health is: ☐Excellent ☐Very Good ☐ Good ☐ Fair ☐ Poor

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PLEASE INCLUDE THE FOLLOWING WITH YOUR APPLICATION MATERIALS:

- **Proof of identification:** Please provide a current government-issued ID, such as a driver's license, state-issued ID card or passport.
- **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)
- **Proof of income:** Please refer to the "Financial Information" section of the application.
- **Bank statement for the last 30 days.**
- **Denial notice from appropriate program (Medi-Cal, Medicare, etc).**
- **Are you currently homeless?** ☐ NO ☐ YES: Provide a letter from a shelter to verify your current status to verify residency. Explain your situation in 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.

MEDICAL BENEFIT INFORMATION

Do you have health insurance through:	**Have you applied for health insurance through:**
☐ Medi-Cal, Type: _____	☐ Medi-Cal, Type: _____
☐ Medicare	☐ Medicare
☐ Covered California *(Obamacare)*	☐ Covered California *(Obamacare)*
☐ Other private health insurance _____	☐ Other private health insurance _____
Does your employer or your spouse's employer offer health insurance? ☐ NO ☐ Yes If you responded "yes" please explain why you opted out from enrolling for health insurance:	Please explain the status and/or denial reason for each that apply and if your case is pending:

HOUSEHOLD INFORMATION

Total number of people in household: _____

* List yourself, your spouse, legal dependent children and any dependent person in the household 21 years and younger (You do not need to list roommates who are not dependent or who do not contribute to the household income.)

Name	Age	Relationship	Monthly Income ($)

FINANCIAL INFORMATION

To qualify for Project Access, your gross **HOUSEHOLD** income must be at or below 250% of the Federal Poverty Level.

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

TOTAL: $ _____

PLEASE INCLUDE PROOF OF INCOME FROM ALL INCOME SOURCES IN YOUR HOUSEHOLD

☐ **Income from employment.** Provide all pay stubs from you and/or your spouse (if employed) for the last 30 days.

☐ **Income from unemployment.** Provide proof of unemployment.

☐ **Income from Self-Employment.** Provide IRS income tax return from the previous year including Schedule "C", profit and loss form.

☐ **Income from the following:**

- ☐ SSI/Disability
- ☐ Cal Works
- ☐ Child Support
- ☐ Other: _____

Is your household receiving food assistance?

☐ NO ☐ YES - Provide a current Notice of Action award letter with the listed amount awarded per month.

Monthly CalFresh amount: $ _____

☐ **I currently have no income.** Explain how you meet basic needs:

☐ **If you do not have the documentation required. Explain what documentation it is you are missing and the reason you are unable to obtain it:**

DECLARATIONS

Monthly Income	Employment Income (self)	$
	Spouse's Employment Income	$
	Social Security/Disability	$
	Unemployment	$
	Other Income	$
Living Expenses	Rent/Mortgage	$
	Monthly Utilities	$
	Car Payment	$
	Car Insurance	$
	Student Loans	$
	Food	$
	Child Support	$
	Credit Cards	$

Number of Motor Vehicles Owned_____ Total estimated value: $_____

Checking Account Balance: $_____ Bank:_____ Bank Acct. #: _____

Savings Account Balance: $_____ Bank:_____ Bank Acct. #: _____

AUTHORIZATION TO SHARE/COLLECT INFORMATION

I, _____, Date of Birth ___/___/____, allow my doctor(s) and/or any health care providers to release 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 health care providers.

- I understand that my personal health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.
- This authorization may be revoked and/or modified at any time, exception to the extent that action has already occurred. I understand if I revoke this authorization, I must do so in writing.
- I have the right to request in writing a copy of the information being disclosed.
- If applicant is unable to sign this authorization, a legal guardian or other person with lawful authority to act on the applicant's behalf could sign on his/her behalf; and has the right to receive a copy of this authorization, if I request one.

Patient Signature: _____ **Date:** _____

MEDIA RELEASE (OPTIONAL)

Project Access San Diego's designated media spokesperson(s) is (are) authorized to use and or disclose the health information indicated below about me to reporters for news purposes. This information may be released to media representatives for newspaper, magazine, broadcast, web-based or other such media. I understand that reporters for such publications may not be covered by federal privacy regulations and the disclosed information may be redisclosed and is no longer protected by these regulations. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization.

I authorize the use and disclosure of the following information:

- ☐ Name, Age
- ☐ Specific information about injuries or medical condition
- ☐ Medical prognosis
- ☐ City, county, state or residence
- ☐ Other _____

Photo/Audio Taping/Filming Consent:

- I permit photographing, audiotaping or filming for news media purposes.

I understand that I may refuse to sign this authorization and it will not affect my ability to obtain treatment through Project Access San Diego.

Patient Signature: _____ Date: _____

AGREEMENT

You agree that you will: (read carefully—these are requirements of the Project Access program)

- Work with assigned Project Access Patient Care Manager, who will schedule **ALL** of your referral medical appointments and/or hospital visits/surgeries associated with the program's specialists.
- Follow your treatment plan: (i.e.: fill prescriptions and take medications as prescribed by the specialist and follow the specialist's instructions).
- Communicate with your Patient Care Manager after every appointment to notify of next scheduled appointment and/or surgery. If the specialist's office schedules you for a procedure and/or surgery and you fail to communicate this to Project Access immediately, you will be held responsible for all resulting costs/bills.
- Promptly supply any additional information that 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 there is a change in address, phone number, income or if you become eligible for medical insurance through Medicare, Medi-Cal, Covered California, or any other health care coverage.
- Apply for other assistance, such as those assisting with prescription or medical equipment costs, at Project Access' request.
- Keep each appointment. If you miss any appointments without 24 hours' notice, you will be dismissed from the program indefinitely.
- Notify Project Access immediately if you no longer require the medical services for which you were referred.
- Must notify Project Access immediately if you are planning on leaving the county/country for any

amount of time.

You understand that:

- Your eligibility is for 6 months or until you are discharged by the specialist.
- Project Access San Diego is NOT an insurance plan.
- You must show up ON TIME to all appointments.
- You must notify your care manager at least one week in advance of an appointment if you need transportation and/or interpretation for your appointment.
- Providing false or misleading information on this application or in supporting documents will 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 you will be dismissed from the program. If you know you cannot make an appointment, you must let Project Access know immediately in order for Project Access to reschedule your appointment.
- Emergency room, ambulance services, past medical bills, and **medical appointments you arrange on your own** are not covered by Project Access.
- Only medications prescribed by a PASD specialist and approved by your care manager will be covered. If a prescription assistance program is available, your care manager will help you apply for prescription coverage. You are expected to pay for medications on the $4 or $10 formulary and any that are within your financial means.
- If the specialist orders laboratory services, you must communicate this to your community clinic in order for your primary doctor to place the laboratory order at your community clinic. Laboratory costs are the patient's responsibility.

You certify that:

- You live in San Diego County.
- Your income meets Project Access guidelines.
- You do not have healthcare insurance, nor do you qualify for health insurance through public assistance programs or through employer.
- You have enclosed all supporting documents required for enrollment qualification:
  - ➔ Complete and signed application
  - ➔ Copy of government-issued identification card
  - ➔ Proof of San Diego County residency
  - ➔ Bank statements for the past 30 days
  - ➔ Proof of income for the past 30 days
  - ➔ Signed medical release form
  - ➔ Signed media release form (optional)

I hereby certify that all application materials in addition to the above circumstance declaration information are true and complete. I certify that all I have declared is based on my best of knowledge. I understand that by supplying false information I will be held responsible for 100% of my medical expenses provided under the program of Project Access San Diego.

Patient Signature: _____ Date: _____