

**PATIENT INFORMATION**

First Name:		Last Name:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security:	Date of Birth:	Email:
Marital Status:	Cell Phone Number:	Other Phone Number:	
Address:			Zip Code:
Are you currently a San Diego County resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Language:	Race/ Ethnicity:	
Religion: <input type="checkbox"/> None <input type="checkbox"/> Jehovah Witness <input type="checkbox"/> Catholic <input type="checkbox"/> Muslim <input type="checkbox"/> Christian <input type="checkbox"/> Other	Education: <input type="checkbox"/> Less than High School <input type="checkbox"/> HS Diploma/ GED <input type="checkbox"/> College or Higher	Employment Status: <input type="checkbox"/> Seasonal <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Part time <input type="checkbox"/> Full Time	
Emergency Contact Information:			
Name: _____		Phone Number: _____	Relationship: _____
Name: _____		Phone Number: _____	Relationship: _____

**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 San Diego/ Champions For Health (4699 Murphy Canyon Road, Suite 102, San Diego, CA 92123), 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.

Purpose of Request: Continuity of care

- 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 to Project Access San Diego (Champions For Health), 4699 Murphy Canyon Road, Suite 102, San Diego, CA 92123.
- 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/ Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_



**FINANCIAL INFORMATION**

To qualify for Project Access, your gross HOUSEHOLD income must be at or below 322% 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 paystubs 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:**

**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 hour 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
  - 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: \_\_\_\_\_