PROJECT ACCESS
Palm Beach County Medical Society Services
Providing healthcare to the uninsured

3540 Forest Hill Blvd., Ste 101
West Palm Beach, FL 33406

Project Access Enrollment Application

PART 1: Applicant Information

Date:_____

Please complete the three parts of this application and then mail the completed application to the address above.

Name: First _____ Middle _____ Last _____ Maiden _____

Street Address _____ Apt Number _____ City _____ State _____ Zip _____

Date of Birth _____ Birth Country _____ Social Security Number _____ Driver's License Number _____ Gender: Male Female

Home Phone _____ Work Phone _____ Other Contact Phone _____

Race/Ethnicity: ❑ African-American ❑ Asian/Pacific Islander ❑ Caucasian ❑ Hispanic ❑ Other _____

Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed

U.S. Citizen: ❑ Yes ❑ No If No, are you a Legal Permanent Resident? ❑ Yes ❑ No Date of Residency_____

Highest education level completed: _____ Primary Language: _____

How many adults are in your household?_____ How many children under 18 are in your household? _____

Have you lived in Palm Beach County for the past 6 months? (Must be able to show proof) ☐ Yes ☐ No

Are you currently employed? ❑ Yes If yes, Where? _____

❑ No If no, date of last employment. _____

What is your monthly income before taxes? (Must be able to show proof) _____

Have you ever received medical assistance from HCD? ❑ Yes ❑ No

If yes, when?_____ Why was it terminated? _____

Do you currently have Medicaid or Medicare? ❑ Yes ❑ No Do you currently have Health Insurance? ❑ Yes ❑ No

Have you ever received Medicaid, Medicare, or Health Insurance Benefits? ❑ Yes ❑ No

If yes, when?_____ Why was it terminated? _____

Do you have an application for Medicaid, Medicare, or Health Insurance pending? ❑ Yes ❑ No

Do you currently receive Social Security or SSI Disability? ❑ Yes ❑ No If yes, which? _____

Do you have a military related disability? ❑ Yes ❑ No

Have you seen a health care provider in the past 12 months, including Emergency Room, clinic, hospital or doctor?

❑ Yes ❑ No If yes, where? _____ When? _____

Office Use Only **Eligible:** ❑ Yes ❑ No **Income:** = to or < ❑ 200%

Enrolled by: _____ (site) **Date of Enrollment:** _____

Referred to: _____

Physician Appointment Date Appointment Time

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PART 2: Household Information

Date:_____

Name: First Middle Last Maiden

Please complete the following for each family member living with you: (Attach another page if needed)

Name (Last, First, Middle)	What Kin to You?	Age	Married?	Monthly Income (before taxes)	Checking + Savings

If anyone above is self-employed, please indicate amount of monthly business expenses for each: _____

If anyone above owns a vehicle, please indicate year, make, and model _____

If no income, please explain how your basic needs such as food, clothing, shelter, utilities are being met. _____

Please attach to this application your proof of residency and the proof of income for each family member listed above who has income. Acceptable proofs are listed on the attachment. YOUR APPLICATION CAN NOT BE COMPLETED WITHOUT THESE PROOFS.

I certify that the above information is a full and complete disclosure of my income and address. I certify that I am a U.S. Citizen or lawful permanent U.S. resident. 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.

_____ _____

Applicant Signature Date

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PART 3: Patient Responsibilities

Program Overview

No one is being paid for the health care you receive. The care provided to you is being given by Project Access Volunteers without expectation of payment or compensation and is given to and received by you in exchange for limitations on recovery for damages from the volunteer. Doctors, hospitals and many others are **volunteering** their services to help you get well and stay well. This is not insurance or a government entitlement program. Our help may end at any time, for any reason. **Emergency room expenses and ambulance services are not covered.** Your responsibilities, the assistance available, and other conditions may change at any time. By signing this form you agree to follow the Patient Responsibilities listed below and authorize Project Access to verify the information you have provided. We reserve the right to require that you pay for any assistance you may receive based on inaccurate information that you provided.

General Information

You agree that:

- You will **schedule appointments with only** the doctors to which you have been referred.
- You will **keep each doctor's appointment** and notify your doctor's office ahead of time if you cannot keep your appointment. (Missing appointments may result in being dropped from program.)
- You will present your Project Access ID card each time you see your doctor.
- You will follow your treatment plan, for example: get prescriptions filled and take them as directed.
- You will promptly supply relevant eligibility information that may be requested by the program.
- You will immediately contact Project Access staff if your income changes or you become covered by Medicaid, HCD, private insurance or other health care benefits.
- You will apply for Medicaid or other assistance programs at Project Access' request.
- You will contact Project Access immediately with any changes in your address or phone number.

Medications Assistance

You understand that:

- You will call the Project Access each time you get a prescription.
- Many types, but not all medications are available through this program.
- When possible, Project Access will make an application on your behalf for medications through drug manufacturers prescription assistance programs.
- Each time you receive medication from a manufacturer it is responsibility to notify the Project Access Prescription Assistance Coordinator.
- You must present your Project Access prescription card each time you have a prescription filled

By signing below, you confirm that you understand and agree to the above conditions.

Printed Name: _____ Date of Birth: _____
First Middle Last

Applicant Signature: _____ Date: _____

Please mail this completed application to: Project Access, 3540 Forest Hill Blvd., Ste101, West Palm Beach, FL 33406

Palm Beach County Medical Society Services, Inc.
Project Access

Patient Medication Assistance Program
Patient Limited Power of Attorney

If you qualify, Project Access may be able to obtain some of your medication from the pharmaceutical manufacturers. Although the programs vary widely, they almost always require your signature on their application forms. In the interest of time, Project Access is requesting your permission to sign these application forms as your agent, instead of contacting you each time your signature is required.

I,_____(patient name) authorize the Project Access Prescription Assistance Coordinator to sign my name for the sole purpose of requesting medications from the medication's manufacturer and I authorize release of the following information of mine to the medication's manufacturer: i) name; ii) prescription medications and related information, including dosages, frequency, etc.; iii) corresponding diagnosis information; iv) income eligibility information, including social security number; v) other information requested by the manufacturer as a requirement for participation in its medication reimbursement program. Only medications, which Project Access volunteer physicians prescribe me for my care, will be requested.

I understand that the only purpose of the release of the above information is to apply for medication reimbursement from the medication's manufacturer. I also understand that I have the right to revoke in writing this Power of Attorney with respect to the release of information at any time by providing a written revocation to an authorized representative of Project Access.

This Power of Attorney expires one (1) year after the signature date.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Please return completed form to:

Project Access
3540 Forest Hill Blvd., Ste101
West Palm Beach, FL 33406
561-433-3940 phone
561-969-6688 fax

PROJECT ACCESS

Palm Beach County Medical Society Services

RECORDS RELEASE

DATE:_____

TO: _____

_____

_____

I hereby authorize and request you to release the complete medical records in your possession, concerning my illness and/or treatment during the period from _____ through _____, to the personnel of the program named below. Incorporated in this release form is my authorization for you to include any and all information relating to HIV testing and other AIDS diagnostic techniques.

Project Access
Palm Beach County Medical Society Services, Inc.
3540 Forest Hill Blvd. Suite 101
West Palm Beach FL 33406

SIGNED: _____
Patient or Authorized Person

_____

Relationship if other than patient

PRINT PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT'S SOCIAL SECURITY #:_____

Palm Beach County Medical Society Services
3540 Forest Hill Blvd., Suite 101
West Palm Beach, FL 33406
Phone: 561-433-3940 Fax: 561-969-6688
projectaccess@pbcms.org

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helps people get health care when they don't have health insurance. All the doctors are taking care of people for free. Many doctors, hospitals and others are helping. But, Project Access cannot promise to get all the care a person needs. We will do our best to get care for you. If you need health care and can get that care some other way, you should look into doing that.

Treatment decisions will be based on evidence-based clinical guidelines where, if possible, conservative noninvasive options will be the first line of treatment.

Your care and treatment will be dictated by the evaluating physician/s and the availability of resources.

Project Access is run by the Palm Beach County Medical Society Services, Inc.

Introduction

This paper helps you understand the Project Access program and the ways it can help you. You are a part of the program from 3 to 6 months from the time you first see a doctor if you follow the rules. We are giving you a Project Access ID card you should keep it with you all the time. If you have any questions about what you must do, please call the Project Access staff at **561.433.3940**

Patient Rules

- You may go only to the doctors that the Project Access staff sends you to. First you will go to a primary care doctor. If you need another doctor after that (a specialist), the primary doctor will tell the Project Access staff. Be sure that you get the other doctor's name and phone number from the Project Access staff.
- You must call the doctor's office right away if you cannot keep the appointment. Remember, if you don't call, you may be dropped from the program.
- You **must show** your **Project Access ID card** every time you go to a doctor. If you don't, you may not see the doctor or you may have to pay for the visit.
- It is very important that you do what the doctor tells you to. If you get a prescription for medicine, you should get it from the drugstore listed on your drug discount card. Be sure you ask questions if you are not sure what to do.
- **You must call the Project Access staff** if you move or change your phone number. You must call if your income changes. You must call if you get Medicaid or any other health insurance.

Enrollment Period

- You are part of Project Access for at least 3 months. After that, the staff may check to see if you still qualify.

Patient Agreement

- You have signed a responsibility form. This means that if you do not follow the rules the way this handout tells you to, you may be dropped from the Project Access program. Also, you must tell the truth about your income or any other health coverage. If you don't, you might have to pay for any medical care you get.

Special Services

- When you see your doctor, he or she might tell you to get more tests or see another doctor (a specialist). He might even tell you that you need an operation or must go in the hospital for another reason. The doctor will let the Project Access staff know what you need. You must call the Project Access staff so they can help you do what your doctor said. There may be times when Project Access does not have the specialist that you need. If you are very ill and think you need to go to the emergency room, you should do so. But remember, emergency room care is **NOT** covered by Project Access.

_____
Pt. signature

_____
Date

Acceptable Sources of Proof for Project Access

ACCEPTABLE PROOFS OF RESIDENCY (provide one document below)
NOTE: Document must be dated at least 6 months ago or be at least 6 months old

- Copy of valid Florida driver's license or Florida ID card with current address
- Copy of Voter Registration card
- Copy of utility bills or utility company records
- Copy of rent receipt or written statement from non-relative landlord
- Copy of mortgage receipt or written statement from a mortgage company
- Copy of employment records or statement from non-relative employer
- Copy of church records or written statement from clergy
- Envelope of mail postmarked at least 6 months ago with household name and address
- Copy of court child-support order, juvenile court records, or child welfare records

ACCEPTABLE PROOFS OF INCOME (provide one document for each type of income)
EARNED INCOME

- All check stubs from the 1st of last month to the present.
- Or employer's written statement including:
  1) Employer's name, address, and phone number
  2) How much money was earned each pay period from the 1st of last month to the present.

OTHER INCOME

- Copy of check
- Or bank statement showing dividends and interest for bank accounts
- Or written statement from company or union providing pensions or union benefits

SELF-EMPLOYMENT INCOME

- Last year's IRS tax return or business records and receipts

SOCIAL SECURITY INCOME OR SUPPLEMENTAL SECURITY INCOME (SSI)

- Current award notice, letter, or written statement from Social Security Administration
- Or copy of current check or direct deposit slip

WORKER'S COMPENSATION INCOME

- Copy of check/check stub or current award notice, or written statement from Claims Adjuster, Attorney, or Insurance company

EDUCATIONAL GRANTS, SCHOLARSHIPS, LOANS INCOME

- Written statement, letter, or records from School, 0rganizations, clubs, or agency providing benefit

UNEMPLOYMENT COMPENSATION INCOME

- Current award notice

OTHER GOVERNMENT BENEFITS

- Current award notice, letter, or official written statement or copy of current check

CONTRIBUTIONS

- Written statement from person or agency providing the money or making payments for you. Their written statement should include: Their name, address, and phone number, how much money they gave you from the 1st of last month to the present, if the support will continue or when the support will end

CHILD SUPPORT INCOME

- Cancelled checks (1st of last month to present, if possible)
- Or Attorney General collection and distribution records or current court records (court order, court support agreement divorce or separation papers, etc)