Please complete the enclosed application and return to the Project Access Office:

- **You must include copies of the entire household income previous months payroll stubs.**
- **2013/2014 Federal Income Tax Records**
- **Birth Certificate**
- **Photo ID/Drivers License**
- **Proof of Howard County Residency (Bill showing current address and name.)**

Failure to do so will slow down the enrollment process.

MAIL OR DELIVER TO:

PROJECT ACCESS HOWARD COUNTY
Inside: Community Howard West Campus
829 N. DIXON RD. Suite 100
KOKOMO, IN 46901

Open enrollment hours:
Tuesday's & Thursday's
9:00 a.m. – 4:00 p.m.

Any questions, contact Project Access at 854-0544
Fax: (765) 457-2184

Please note: For enrollment in the H.I.P program you will also need a photo ID & your birth certificate.

Date of Screening______________________

PROJECT ACCESS HOWARD COUNTY
Enrollment Application

Last First MI Social Security # Date of Birth Age

Address City Zip Sex Home Phone Work Phone

______ US Citizen ______ Lawful Perm US Resident Township you live in ______________________

Ethnicity (please circle): Black White Hispanic Asian Native American Other:_____________

Education Level: Less than high school High school graduate/GED Some college College Graduate

Marital Status: Married Separated Divorced Single Widowed

Housing (please circle): Own your home Rent Homeless Other:____________________________

Emergency Contact: Name_____________________________Phone__________________________

Have you previously been enrolled in Project Access? ______yes ______no If yes, when?____________

Do you currently have health insurance, Medicare, or Medicaid? ______yes ______no

Have you ever received health insurance, including Medicaid benefits? ______yes ______no

If yes, when and why was it terminated?____

Is there a possibility you will receive Medicare, Medicaid or Health Insurance? ______yes ______no

Comments____

Have you applied for the Healthy Indiana Plan Insurance? _____ yes, if so, when? _________ ________ no

Do you receive any type of disability benefits? ____yes _____no If so, which?____________

Do you currently receive assistance from any State Programs? ______yes ______no

If yes, which____

Do you receive food stamps? ______yes ______no

Did you ever serve in the US military? ______yes ______no If yes:

Number of years of service? ____________ Discharge status? ____________________________

Do yo u currently have a doctor? Yes No Who?___________________________________

How long since you were last seen by a physician or other provider? __________________________

Do you need assístance in obtaining any of your prescription medications? ______________________

Have you been diagnosed as having diabetes? ____

___________________________________case worker use only___________________________________

Enrolled by _________________________ (site) _________ requested enrollment 3mos / 6mos

_______ Obtained verbal consent to forward application to **FSSA DFC**

______________________________**Project Access use only**______________________________

Physician Referred to or current PCP____

Enrollment Period From ________________________to ____________________________

PROJECT ACCESS HOWARD COUNTY
INCOME CALCULATION SHEET and APPLICANT STATEMENT

Name ______________________________________ SS/IDN ____________________
Last First MI

Address ____
Street City Zip

Household Member	Age	Relationship	Monthly Gross Income	Income Source*

TOTAL MONTHLY HOUSEHOLD INCOME $ ____________

***work, child support, unemployment, alimony, SS/Pension, SSDI, Interest, Cash Assistance**

If no countable income explain:

____

____

Employer ____________________________ if none, last date of employment______________

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

The above statement is being utilized for documentation of address and income eligibility criteria. Attach documentation (recent pay stubs, last tax return, residency proof, etc.)

Income: ☐ ≤ 100% ☐ 101 – 150% ☐ 151 – 200% ☐ Used Earned Income Deduction

Existing physician if any/Other Comments: ____

____

AUTHORIZATION FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the Blocks 1 - 7 must be completed. If any block is *not* completed then this "Authorization Form" will be considered incomplete and defective and cannot be used. *PLEASE PRINT ALL INFORMATION.*

Block 1: Identification of Patient
PATIENT NAME: ____ **DATE OF BIRTH**: ____________________
PATIENT'S ADDRESS: ____

Street [Apt. number, P.O. box - as applicable] , City, State & zip code.

SOCIAL SECURITY NUMBER or OTHER IDENTIFIER:(*e.g.* patient acct # of DL #): ________________________________

Block 2: Type of Records / Information to be Disclosed----*CHECK ONLY ONE OF THE FOLLOWING BOXES* (A or B). If neither box is checked or if both boxes are checked then this form will be considered defective and cannot be used. IF YOU WANT BOTH TYPES OF RECORDS DISCLOSED YOU MUST USE TWO SEPARATE FORMS - One for Each Purpose.

☒ A. Records *except* for Psychotherapy Notes ☐ B. Psychotherapy Notes only.

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED (*examples: All records, X-Rays only, records for last 12 months*)
AND/OR CHECK ALL THAT APPLY: ☒ All Records ☐ alcohol/drug evaluation or treatment ☐ HIV/Aids Status

***All** includes inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/Aids, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices whether or not you created those records as long as the records are in your control or possession.

Block 3: Persons, facility, or class of persons who are authorized to disclose (provide) the records / information: Project Access Howard County program, its agents and employees, FSSA Division of Family and Children, Howard County Trustees, participating clinics, physicians, hospitals, pharmacies, contracted Pharmacy Benefits Manager, providers of durable medical equipment, and other participating health care providers, and pharmaceutical companies.

Block 4: Persons, facility, or class of persons who are authorized to receive the records / information: Project Access Howard County program, its agents and employees, FSSA Division of Family and Children, Howard County Trustees, participating clinics, physicians, hospitals, pharmacies, contracted Pharmacy Benefits Manager, providers of durable medical equipment, and other participating health care providers, and pharmaceutical companies.

Block 5: Expiration: This "Authorization" will expire on ________________(MM/DD/YY)[cannot exceed 1 year from date below] or on the following specific event: ____

Block 6: Purpose for which you want records/information disclosed: (*check one box*) ☒ At request of individual OR
☐ Other: (*state reason*) ____

Block 7: Authorizing Signature

- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law, including alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a *written* revocation to:
  Project Access 825 N. Dixon Rd., Kokomo, IN 46901
- If I revoke this authorization it will have *no* effect on actions already taken on reliance on this form.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.
- By signing below, I acknowledge my receipt of the Project Access Notice of Privacy Practices.

____ ______________________________
Signature of Patient or Patient's Personal Representative **Date of Signature**
Personal Representative's Relationship / Capacity to Patient:____
Printed Name of Personal Representative: ____
Address & telephone number of Personal Representative: ____

NOTE: If a Health Care Provider seeks an authorization from an individual for use or disclosure of protected health information, the Health Care Provider must provide a copy of this signed authorization to the individual.

PROJECT ACCESS HOWARD COUNTY

Patient Responsibility Agreement

I hereby state that I am a Howard County resident and have provided residency documentation.

I do not have any form of insurance, nor do I have the financial resources to cover the costs of health care. I am also not eligible for any state or federal medical assistance programs.

I have provided my health access coordinator with all possible documentation and have truthfully disclosed my financial and medical information.

I agree to follow the established plan of care and recommendations of the physician, so that I will maintain the best possible health. I also understand that refusing to follow the physicians care plan may result in my dismissal of the program.

I understand that I must contact my doctor if I cannot keep my appointment. I may not miss more than one appointment (no show) without contacting my doctor or I may be dismissed from the program.

I understand that I must conduct myself in an appropriate manner in the doctor's office.

I hereby release Project Access and any of its employees, associates or volunteers from any responsibility for changes in my health or well being as a result of the care given.

____

Patient Name   Date

Or

( ) Minor, under 18 years
( ) Physical/Mental Condition

____

Spouse, Parent, Legal Guardian or Representative   Date

____________________   ________________________________

Relationship   Witness   Date

PROJECT ACCESS

APPEAL PROCEDURE

Persons have a right to appeal if they are told that they are ineligible for Project Access enrollment. The following outlines the steps to be followed in filing an appeal.

Step l Prepare a written statement with the following information:

A. The full name, address and telephone number of the person appealing,

B. A clear and brief statement of the facts, including relevant dates,

The statement must be signed and dated and sent to the Project Access office within five (5) working days after the eligibility interview. A copy of this form must be signed and returned with that statement. Please send to:

Project Access Howard County
825 N. Dixon Road
Kokomo, IN 46901

Step 2 The Project Access Howard County Board of Directors will review the appeal at their next scheduled meeting, and will provide a written response within five (5) working days of their decision.

I hereby certify that I have received a copy of the Project Access Appeal Procedure

____
Signature Date