PROJECT ACCESS APPLICATION

- **You must include copies of the entire household income for the previous month (last 30days).**
- **The last Federal Income Tax Records**
- **Birth Certificate**
- **Photo ID/Drivers License**
- **Proof of Howard County Residency (Lease agreement, utility bill, phone bill, car registration)**

Failure to provide all needed documents will slow down the enrollment process!

MAIL OR DELIVER TO:
PROJECT ACCESS HOWARD COUNTY
Inside: Community Howard Specialty Hospital
829 N. DIXON RD. Suite 100
KOKOMO, IN 46901

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

Phone: (765) 854-0544
Fax: (765) 457-2184

Call with any questions about application or enrollment process!

PROJECT Access of Howard County
• Project Access • Dentists Delivering Smiles
• Medication Assistance • Diabetes Navigator
"Access to Healthcare"

United Way

CENTER TOWNSHIP

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 assistance in obtaining any of your prescription medications? _____

Have you been diagnosed as having diabetes? _____

Project Access staff to complete

Enrolled by _____ (site) _____ requested enrollment 3mos / 6mos

_____ Obtained verbal consent to forward application to FSSA DFC

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 **$** _____

***Employment, 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

Project Access Staff use only

The above statement is being utilized for documentation of address and income eligibility criteria. Attach documentation with this application.

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 re-disclosed 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 829 N. Dixon Rd. Suite 100, 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.

DFRAZAE01

AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE

State Form 55366 (R2 / 12-14) / DFR 2123HC

Section 1

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. The representative may be an individual or an organization. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

Section 2

Name of Representative (*Please print clearly*)

Check association with applicant/recipient. Please select ONE (*1*).

☐ Attorney	☐ Eligibility Assistance Company	☐ Friend	☐ Family
☐ Institution of Residence	☐ Waiver Case Manager	☐ Other (*Specify*): _____	

Mailing Address (*number and street, city, state, and ZIP code*)

FUNCTION	FUNCTION DESCRIPTION	SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO: HEALTH COVERAGE
APPLY	• Sign application and be interviewed. • Provide all required proof of information necessary to determine eligibility for benefits. • Receive the Notice of the application decision. • Speak on applicant's behalf at a hearing if the application decision is appealed.	Apply ☐
ONGOING	• Report changes. • Attend periodic redeterminations. • Receive the appointment notices and any redetermination mail-in forms. **NOTE:** Do not check this function if the representative will not continue to act on recipient's behalf after the application decision is made.	Ongoing ☐

In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I agree to maintain or be legally bound to maintain the confidentiality of any information regarding the applicant/recipient provided by the Division of Family Resources.

Signature	Date (*mm/dd/yyyy*)	Telephone ((###) ###-####)

Section 3

I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.

Applicant/Recipient Name	Applicant/Recipient Signature	Date (*mm/dd/yyyy*)

Case Number (*Optional*)	Applicant/Recipient Date of Birth (*mm/dd/yyyy*)	Applicant/Reciipient Social Security Number
		XXX-XX-

PROJECT ACCESS HOWARD COUNTY

Memorandum of Understanding

This Memorandum of Understanding is made and will be effective on _____ day of _____, 20____

BETWEEN

_____

Print First and Last Name

AND

PROJECT ACCESS HOWARD COUNTY

Project Access Howard County provides assistance to patients to receive access to health care. This assistance may include: a primary physician or a clinic for little or no cost to the patient; assistance with filling paperwork out for possible health insurance programs available in our State.

In helping the patient gain access to health care, Project Access expects the patient to follow up as recommended with the insurance companies to know if they receive coverage or why they didn't receive coverage. Due to these issues being time sensitive the patient will need to follow up on their applications for health care. This is the patient's responsibility and failure to be cooperative in this area could lead to dismissal from our program here at Project Access.

A lack of effort from the patient may include, but not limited to, the following:

1. **Not paying for health insurance for which the patient has been accepted**
2. **Not accepting health insurance for which the patient has been accepted**
3. **Intentionally not filling out paperwork required to receive health insurance**
4. **Not attempting to receive further education**
5. **Any denial from the patient of an opportunity that would further his or her ability to, in any way, receive health care.**

_____ _____

Signature **Date**

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 Signature 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 I 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:

HCMS Project Access
829 N. Dixon Road
Kokomo, IN 46901

Step 2 The HCMS Board of Directors will review the appeal and provide a written response within five (5) working days of receipt of the appeal.

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

Signature Date