GREATER BIRMINGHAM PROJECT ACCESS

Program Application

CHECK ONE:
▢ New Patient
▢ Renewing Patient

Please Print LEGIBLY.

APPLICANT INFORMATION				
Last Name:	First Name:			MI:
Date of birth:		SSN:		
Current Address:			Apt #:	
City:	Zip Code:		State:	County:
Circle one: Male or Female	Marital status:	Cell Phone:	Home Phone:	Email:
SPOUSE INFORMATION				▢ **N/A**
Last Name:	First Name:		MI:	
Date of birth:			Phone:	
EMERGENCY CONTACT				
Name:			Relation to Patient:	
Address:				Phone:
City:			State:	Zip Code:
REFERRAL SOURCE				
How did you hear about us?:				
What clinic is referring you to Project Access?				Phone Number:
Do you have a Primary Care Physician (PCP)?	PCP Name:		PCP Clinic:	
APPLICANT/PATIENT INCOME INFORMATION				▢ **N/A**
Employer:			Employer Phone:	Fax:
Employer Address:			How long have you worked at your current job?	
City:			State:	Zip Code:
Position:		Hourly OR Salary		Annual Income:
Other Income Source:			Total Annual Amount:	
If you are not currently working, who is supporting you?:			Relationship:	Phone:

SPOUSE EMPLOYMENT/INCOME INFORMATION				▢ N/A
Employer:			Employer Phone:	
Employer Address:			Length of employment?	
City:			State:	Zip Code:
Position:	Hourly OR Salary CIRCLE ONE			Annual Income:

DEPENDENTS/HOUSEHOLD INFORMATION (List all names, DOB, and relationship of any and all individuals living with you)		
Name	**Date of birth**	**Relationship**

FINANCIAL APPLICATION			
Income/Personal Assets		**Monthly Living Expenses**	
Social Security:	Cash on Hand:	Mortgage:	Other:
SSI/Who receives?:	Savings Account:	Rent:	Other:
V.A. Pension:	Checking Account:	Electric:	Other:
Unemployment:	Investments:	Gas:	Other:
Worker's Compensation:	Life Insurance:	Telephone:	Other:
Interest Income:	Property:	Water:	Other:
Divided Income:	Financial Settlement:	Food:	Other:
Child Support: :	Other:	Car Gasoline:	Other:
Alimony:		Car Payment:	Other:
Rent:		Car Insurance:	
WIC:		Daycare:	
Food Stamps:		Child Support:	
TOTAL:	**TOTAL:**	**TOTAL:**	**TOTAL:**

PROJECT ACCESS PATIENT INFORMATION AND MEDICAL HISTORY					
Patient Name (Nombre):				Date of birth (fecha de nacimiento):	
Pharmacy Name (Nombre de la farmacia):				Pharmacy Phone (numero de telefono):	
Use of alcohol (toma alcohol):	Never (Nunca)	Rarely (Raramente)	Moderate (moderamente)	Daily (con frecuencia)	
Use of illegal street drugs (Uso de drogas ilícitas):	Never (Nunca)	Rarely (Raramente)	Moderate (moderamente)	Daily (con frecuencia)	
Use of tobacco products (uso de productos de tabaco):	Never (Nunca)	Rarely (Raramente)	Moderate (moderamente)	Daily (con frecuencia)	
Diabetes (Diabetes)	No (no)	Yes (si)	Heart trouble (Problemas de corazón)	No (no)	Yes (si)
High Blood Pressure (Presion sanguinea alta)	No (no)	Yes (si)	Kidney trouble (Enfermadad de riñones)	No (no)	Yes (si)
Cancer of (Cáncer de): _________________	No (no)	Yes (si)	Liver disease (Enfermedad del hígado)	No (no)	Yes (si)
Stroke (Derrame cerebral)	No (no)	Yes (si)	COPD (Enfermedad pulmonar obstructiva crónica)	No (no)	Yes (si)
Any other illnesses? (¿Cualquier otra enfermedad?):					
Have you been vaccinated for COVID-19?	No (no)	Yes (si)			
What COVID-19 vaccine did you receive? (¿Qué vacuna contra el covid-19 recibiste?)			How many doses of the vaccine have you received? (¿Cuántas dosis de la vacuna ha recibido?)		
Do you have health insurance? (¿Tienes seguro médico?)	Does your employer (or spouse's employer) offer health insurance? (¿Su empleador (o el empleador de su esposo) ofrece seguro médico?)		Have you applied for Disability/SSI? (¿Ha solicitado beneficios por discapacidad o SSI? Date of application (fecha de aplicación): If approved, effective date (si se aprueba, fecha de vigencia): (need original letter with date of approval)		

OTHER DEMOGRAPHIC INFORMATION	
Are you a veteran? (Eres una veterano):	Are you eligible to go to the VA for healthcare?
Have you received or currently receive healthcare at Cooper-Green Hospital? (¿Ha recibido atención médica en el pasado en Cooper-Green Hospital?):	
Country of birth (país de nacimiento):	Country of citizenship (País de ciudadanía):
Preferred language (idioma preferido):	Other languages spoken (otras idiomas hablados):

STATEMENT OF UNDERSTANDING
(Declaración de Entendimiento)

I promise that everything I have stated in this application is true. Greater BIrmingham Project Access (GBPA) is authorized to check my credit and employment history. If approved and admitted into GBPA program, I give GBPA permission to release the above information, both medical and financial, to drug companies, and physicians involved in my care. If approved and admitted, I agree to abide by the policies and procedures of the Project Access program. Any false or fraudulent information submitted will result in permanent suspension from the program.

Prometo que todo lo que he dicho en esta solicitud es cierto. Greater BIrmingham Project Access (GBPA) está autorizado para verificar mi historial crediticio y laboral. Si se aprueba y es admitido en el programa GBPA, doy permiso a GBPA para divulgar la información anterior, tanto médica como financiera, a las compañías farmacéuticas y a los médicos involucrados en mi atención. Si es aprobado y admitido, acepto cumplir con las políticas y procedimientos del programa Project Access. Cualquier información falsa o fraudulenta presentada resultará en la suspensión permanente del programa.

Applicant's signature:____________________________________ Date: ________________

Mail completed application to:
Greater Birmingham Project Access
1130 22nd Street South
Birmingham, AL 35205

OR

FAX application to:
205-838-6294

Program Phone Numbers:
Main Program Number: 205-558-3403
Google Voice Number: 205-202-1598