

GREATER BIRMINGHAM PROJECT ACCESS

PROGRAM APPLICATION

APPLICANT INFORMATION			
Last Name:		First Name:	MI:
Date of birth:		SSN:	
Current address:			Apt#:
City:	State:	ZIP	COUNTY:
Male _____ Female _____	Marital Status:		Home Phone: Cell Phone: e-mail:
INCOME INFORMATION			
Current employer:			
Employer address:			How long at current job?
Phone:	E-mail:		Fax:
City:	State:		ZIP Code:
Position:	Hourly	OR	Salary (<i>circle</i>) Annual income:
Other Income Source:		Annual Amount:	
Other Income Source:		Annual Amount:	
EMERGENCY CONTACT			
In case of an emergency, contact:			
Address:			Phone:
City:	State:		ZIP Code:
Relationship:			
SPOUSE INFORMATION			
Last Name:		First Name:	MI:
Date of birth:		Phone:	
SPOUSE EMPLOYMENT INFORMATION			
Current employer:			
Employer address:			How long?
Phone:	E-mail:		Fax:
City:	State:		ZIP Code:
Position:	Annual income:		
HOUSEHOLD INFORMATION			
List names, DOB, and relationship of any individuals currently living with you			
NAME	Date of Birth	Relationship	

REFERRAL SOURCE

Who referred you:

Phone Number:

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

If you are not currently working, who supports you?

Relationship:

Project Access Patient Information and Medical History

Name (Nombre) _____ DOB (fecha de nacimiento) _____

Pharmacy Name and Phone Number (Nombre de la farmacia y numero de telefono) _____

Use of alcohol (toma alcohol):	Never (Nunca)	Rarely (Raramente)	Moderate (moderadamente)	Daily (con frecuencia)
Use of street drugs (Uso de drogas ilícitas):	Never (Nunca)	Type (tipo):		Frequency (frecuencia):
Sexually active (sexualment activo):	Never (Nunca)	Since (Desde):		

Current Medications (Medicamentos que esté tomando)	Past Surgeries or Hospitalizations (Cirugías/Hospitalizaciones)		Allergies (Alergias)

Diabetes (Diabetes)	No (no)	Yes (si)	Back problems (problemas de espalda)	No (no)	Yes (si)
Insulin use (uso de insulina)	No (no)	Yes (si)	Arthritis (Artritis)	No (no)	Yes (si)
High blood pressure (Presión sanguínea alta)	No (no)	Yes (si)	Gout (Gota)	No (no)	Yes (si)
Cancer of (Cáncer de):	No (no)	Yes (si)	Chicken Pox (Varicelas)	No (no)	Yes (si)
Stroke (Derrame cerebral)	No (no)	Yes (si)	Measles (Sarampion)	No (no)	Yes (si)
Heart trouble (Problemas de corazón)	No (no)	Yes (si)	Mumps (Paperas)	No (no)	Yes (si)
Kidney disease (Enfermedad de Riñones)	No (no)	Yes (si)	Diphtheria (Difteria)	No (no)	Yes (si)
Liver disease (Enfermedad del Hígado)	No (no)	Yes (si)	Smallpox (viruela)	No (no)	Yes (si)
Sleep apnea (Apnea del sueño)	No (no)	Yes (si)	Pneumonia (Neumonía)	No (no)	Yes (si)
Bleeding tendency (Tendencias de hemorragia)	No (no)	Yes (si)	TB (Tuberculosis)	No (no)	Yes (si)
Anemia (Anemia)	No (no)	Yes (si)	Hepatitis (Hepatitis)	No (no)	Yes (si)
COPD (Enfermedad pulmonar obstructiva Crónica)	No (no)	Yes (si)	Venereal disease (Enfermedades venéreas)	No (no)	Yes (si)
Bronchitis (Bronquitis)	No (no)	Yes (si)	HIV + or AIDS (VIH-SIDA)	No (no)	Yes (si)

Any other illnesses?(¿Cualquier otra enfermedad?): _____

Family Medical History (Historia de la familia):

What is the health status of your family (Cuál es el estatus de salud de su familia)?

Mother (Madre): _____ Father (Padre): _____

Brothers/Sisters(Hermanos/Hermanas): _____

Any family history of the following (Cualquier historial familiar de lo siguiente):

Diabetes (Diabetes)	No (no)	Yes (si)	Cancer-if yes, list type (Cáncer si es así , liste qué tipo)	No (no)	Type (Tipo):
Heart disease (enfermedad del corazón)	No (no)	Yes (si)		Yes (si)	
High blood pressure (presión alta)	No (no)	Yes (si)	Other family disease (otras enfermedad familiar):		
Stroke (derrame cerebral)	No (no)	Yes (si)			

Do you have health insurance? Name:	Does your employer (or spouse's employer) offer health insurance?	If yes, what is the monthly cost to you/your spouse?	<i>Note: Need letter from employer stating benefits and premium amounts.</i>
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Insurance available through (name of Employer):	Have you applied for Disability/SSI? Date of application:	If approved, effective date: (need original letter with date of approval)
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OTHER DEMOGRAPHIC INFORMATION

Are you a veteran?	Are you eligible to go to the VA for healthcare?
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Have you received healthcare in the past at Cooper-Green Hospital?	Do you currently receive healthcare at Cooper-Green Hospital?
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Country of birth:	Country of Citizenship:
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Preferred Language:	Other languages spoken:
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STATEMENT OF UNDERSTANDING

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 Access-to-Care Program. I understand that this is a program meant to assist individuals for a temporary period of time.

Applicant's Signature: _____ Date: _____

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Mail: Greater Birmingham Project Access
1 Medical Park Drive East
Birmingham, AL 35235

Phone: 205-838-3421

or **FAX:** 205-838-6294



(Updated 6/02/2021)