PROJECT ACCESS

Program Application

***Incomplete and/or unsigned applications will not be accepted**

APPLICANT INFORMATION			
Last Name:	First Name:		MI:
Date of birth:	SSN:		
Current Address:			Apt #:
City:	State:	Zipcode:	Gender:
What county do you live in?	Phone Number:	Email:	
Marital Status (circle one): Single Living Together Engaged Married Separated Divorced Widowed Other:_____			
Country of Birth:	Country of Citizenship:		
Preferred Language:	Other languages spoken:		
SPOUSE/SIGNIFICANT OTHER INFORMATION			▢ **N/A**
Last Name:	First Name:	MI:	
Address:	Phone:		
EMERGENCY CONTACT			▢ **Same as Above**
Name:	Relation to Patient:		
Address:	Phone:		
REFERRAL SOURCE			
What clinic/doctor is referring you to Project Access?	Phone Number:		
Do you have a Primary Care Physician (PCP)? Yes OR No	**PCP Name/Clinic:**		
Clinic caseworker/social worker's name (if applicable):			
APPLICANT EMPLOYMENT/INCOME INFORMATION			▢ I do not work
Employer/Income Source:			
Position:	How long have you worked at your current job?		
Does your Employer offer health insurance?			
How many hours do you work per week?	Employment Income:		Hourly OR Salary
If you are not currently working, who is supporting you?:	Relationship:		

SPOUSE/SIGNIFICANT OTHER EMPLOYMENT/INCOME INFORMATION		▫ I do not work
Employer/Income Source:		
Position:	How long have you worked at your current job?	
Does your Employer offer health insurance?		
How many hours do you work per week?	Employment Income:	Hourly OR Salary

DEPENDENTS/HOUSEHOLD INFORMATION (List any and all individuals living with you)

Name	Date of birth	Relationship

PATIENT MEDICAL INFORMATION

Which pharmacy do you use?

Have you ever been diagnosed with any of the following (please circle answer):

Diabetes	No	Yes	**Heart trouble**	No	Yes
High Blood Pressure	No	Yes	**Kidney trouble**	No	Yes
Cancer (type:_____)	No	Yes	**Liver disease**	No	Yes
Stroke	No	Yes	**COPD**	No	Yes

Do you have any other illnesses or chronic conditions you would like us to know about?

Do you take any medicines you would like us to know about?

Do you currently see a doctor at UAB Hospital? If yes, please provide doctor's name or clinic:

Have you ever applied for Disability/SSI?	If yes, what is the status of your application?	Have you ever received care at Cooper Green Hospital?	Are you a Veteran?
Yes OR No		Yes OR No	Yes OR No

FINANCIAL APPLICATION (For yourself and spouse/significant other)

Income/Personal Assets		Monthly Living Expenses	
Social Security:	Cash on hand:	Rent/Mortgage:	Child Care:
SSI/SSDI:	SNAP/WIC::	Gas:	Car Insurance:
Pension:	Rental Income:	Electric:	Car Payment:
Unemployment/Workers Comp:	Investments/Dividends:	Telephone:	Debts:
Child Support:	Property:	Water:	Other:
Alimony:	Financial Settlement:	Food:	Other:

BANK/TAX/INCOME ATTESTATION (For yourself and spouse/significant other)

Please check the box(es) for any item that you do NOT have and then initial on the line:

☐ **Bank Accounts:**
I do hereby certify that I do not have any bank accounts (savings or checking). Please accept this as verification that I do not have a bank account.

Applicant Initials:_____ Spouse/Significant Other Initials (if applicable):_____

☐ **Taxes:***(if you and/or your spouse have a SSN or ITIN, you MUST provide a tax return or transcript of nonfiling)*
I do hereby certify that I do not file federal or state income tax for the year _____. Please accept this letter as verification that I do not file taxes.

Applicant Initials:_____ Spouse/Significant Other Initials (if applicable):_____

☐ **Income:**
I do hereby certify that I am unemployed and do not have any work income, social security, disability, or any other form of income.

Applicant Initials:_____ Spouse/Significant Other Initials (if applicable):_____

I attest that all the financial information I have reported here is true, I understand that providing any false or fraudulent information may result in application denial and/or result in my removal from the program.

Applicant Signature:_____ Spouse/Significant Other Signature:_____

STATEMENT OF UNDERSTANDING & CONSENT TO RELEASE INFORMATION

I hereby certify that everything I have stated in this application is true to the best of my knowledge. I understand that I must complete this application completely and submit any required supplemental documentation to complete my application before an admission decision can be issued. I authorize Greater Birmingham Project Access (GBPA) to use and disclose my protected health information to anyone involved in my care, including but not limited to: physicians, clinics and drug companies. If approved and admitted, I agree to abide by the policies and procedures of the GBPA program. I agree to report any changes in my financial and/or insurance status to GBPA immediately.

Applicant's signature:_____ **Date:** _____

Please submit your completed application and supplemental documents to Project Access:
Email: alprojectaccess@uabmc.edu
Fax: 205-838-6294
If you have any questions, please call us at 205-202-1598