PIERCE COUNTY PROJECT ACCESS

223 Tacoma Ave. S. ✦ Tacoma, WA 98402-2513
✦ Phone: 253.572.7265
✦ Fax: 253.666.6802

REQUIRED DOCUMENT CHECKLIST FOR APPLICATION

To Patient: Please read below and provide documentation with your application.

PROOF OF RESIDENCY

To be eligible for this program you must have lived in Pierce County for at least 3 months. We do not accept driver's license to prove residency.

a. Documents accepted for residency verification (provide **one** document from this list)
- ❑ Utility bill with your name on it dated three months prior to referral
- ❑ Copy of your food assistance letter with address that matches address on application
- ❑ Lease agreement with your name and address

PROOF OF FINANCIAL STATUS

To be eligible for this program you must be under 200% of the Federal Poverty Level. Please provide a copy of **one** of the following documents.

b. Documents accepted for income verification (include **one** from this list)
- ❑ Copy of your food assistance letter
- ❑ Two pay stubs from within the last three months
- ❑ Current copy of IRS tax return
- ❑ Unemployment benefits letter
- ❑ Bank statements from last three months
- ❑ SSI award letter
- ❑ Child support award letter

NOTE: You do not have to be a US citizen to be eligible for Pierce County Project Access.

INCOMPLETE REFERRALS

1. Incomplete applications will not be processed until complete.

2. It is the responsibility of the referring clinic or agency to communicate with the patient regarding application status. After enrollment, PCPA will communicate appointment information and referral status with the patient.

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PATIENT ENROLLMENT APPLICATION

PATIENT INFORMATION

Patient's last name First Middle	❑ M ❑ F	DOB:
Street Address Apt. # City Zip		How long at this address?
Email:		How long lived in Pierce County?
Best phone number to reach you: ❑ Home ❑ Mobile	Alternate phone number: ❑ Home ❑ Mobile	Text ok? ❑ Yes ❑ No
Race/Ethnicity / Preferred spoken language / Do you need an interpreter? ❑Yes ❑ No		Do you have reliable transportation? ❑Yes ❑ No
If interpreter is needed, please provide name and phone number of English speaking contact:		❑ Married ❑ Single

HOUSEHOLD AND EMPLOYMENT INFORMATION

Employer Name (if you work) ❑ Unemployed	Do you receive food stamps? ❑ Yes ❑ No
Monthly household income $	How many people in your household (that you are responsible for by marriage, birth or adoption) are supported by the monthly household income? # People (including yourself)

Please check all boxes that apply to how you receive income and provide documentation:

❑ SSI	❑ Disability	❑ Unemployment	❑ Child Support	❑ VA Benefits
❑ Lottery	❑ Spousal Support	❑ Inheritance	❑ Litigation Settlement	❑ Employment
❑ Self-Employed	❑ Pension/Retirement	❑ Other (Please Explain)		

What is your housing situation? ❑Homeless ❑ Staying with family/friends ❑ Homeowner ❑ Rent ❑ Staying in a Shelter

❑ Other (Please Explain)

Are you a homeowner? ❑ Yes ❑ No	Current checking and savings account balance combined $

Is there any other information about your current financial situation that you would like PCPA to know?

HEALTHCARE AND INSURANCE INFORMATION

Is the medical care you need a result of an on-the-job injury? ❑ Yes ❑ No

Is the medical care you need a result of a car accident or injury caused by another person? ❑ Yes ❑ No

Do you have any of the following? (please circle)

Stroke	Heart Disease	Congestive Heart Failure	Hypertension	Cancer	Depression
Diabetes	HIV/AIDS	Cardiovascular Disease	Asthma	Anemia	Thyroid Disorder

Substance Abuse: ❑ Active ❑ History of ❑ N/A Are you pregnant? ❑ Yes ❑ No

Do you have medical insurance? ❑ Yes ❑ No If "yes" to any of these, please attach copy of insurance card

❑ Commercial Insurance ❑ DSHS ❑ Basic Health ❑ COBRA ❑ TriCare

Have you applied for Medicaid? ❑ Yes ❑ No If "yes", list application date Denied? ❑ Yes ❑ No

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PATIENT AGREEMENT

I understand and agree that:

- My eligibility is for 6 months. If requested by a PCPA physician, an extension may be granted.
- I will:
  - Keep every doctor's appointment. If I miss an appointment without cancelling at least two days in advance, I will not be rescheduled and will no longer be eligible for services through PCPA.
  - Present my PCPA Enrollment card each time I see a doctor or other health care provider through PCPA.
  - Follow my PCPA medical plan and the advice of my PCPA medical providers.
  - Quickly supply information to PCPA program staff when I am asked.
  - Notify PCPA immediately if my address or phone number changes.
- PCPA will not pay for medications.
- All of the care I need may not be available through PCPA. PCPA is an outpatient, nonemergency program. Emergency room visits are not covered.
- PCPA does not pay past medical bills.
- If I start to receive Medicaid, Medicare, or other health insurance, I will inform PCPA.
- If my income or family size changes, I may become eligible for state or other insurance for which I am not currently eligible. I will seek coverage for which I am eligible and will inform PCPA.
- I will be disenrolled from the program if it is found that I have intentionally misrepresented information regarding finances and/or enrollment in medical assistance programs.

I promise that:

- I live in Pierce County.
- The information I have given in this application is accurate and complete to the best of my knowledge.

CONSENT FOR CARE INFORMATION: By signing this form, I give permission to share my medical information as necessary with Pierce County Project Access and for PCPA to share medical information as necessary in the diagnosis and treatment of my health problems. I understand that my health information and information of any care and services, including costs, will be provided to PCPA. PCPA will use this information in the aggregate and for recognition purposes, among other things.

By signing below, I confirm that I understand and agree to the information above.

Patient Signature _____ Date _____

Your enrollment application will not be processed without the requested documents. Please include and attach to the Patient Enrollment Application form all documents needed and fax or mail them. Please allow one week for processing.

Please return documents to: