Project Access Johnston County/Enrollment Application2

Enr Date_____ Re/Dates_____ _____ _____ _____ _____ _____ _____ _____

ID #___-___-___-___ Reason if not eligible or MOGE_____

Do you currently have or qualify for <u>any</u> type of health insurance, hospitalization insurance, catastrophic insurance, worker's compensation, Medicare or Medicaid *(excluding Family Planning)*?	☐ Yes ☐ No	If yes, which one(s)?

Patient Name(include middle initial)

P.O.Box(where you receive mail) ***and*** Street Address(where your house is located) City Zip

Home Phone # Work Phone # Cell Phone

Date of Birth Age Sex Social Security #

Emergency Contact:_____
Name Phone Relationship

Marital Status: ☐Married ☐Separated ☐Divorced ☐Single ☐Widowed

Race: ☐American Indian ☐Asian ☐Black/African American ☐Hispanic/Latino ☐White/Caucasian ☐ Other		
Do you have any children under age 18?	☐Yes ☐No	If yes, how many?
Number of people in your household:	If not married, what are your living arrangements? Include parents, other relatives roommate(s), significant other, friends, other	
Housing arrangements? ☐Own ☐Rent ☐Homeless ☐Other?_____		
What is your highest level of education? ☐Less than high school ☐High school ☐Some College ☐College graduate		

List any current health concerns: ***Anxiety/Depression?*** ***Recent Weight loss or gain?***	**List All Medications (include vitamins):**	**Allergies:** **(Food and Drug)**

Family Medical Concerns: Circle all that apply:
High blood pressure
Heart condition
Kidney Disease **Cancer**
Depression
Diabetes
Lung/Breathing

***Spiritual Assessment:**
Have you had any major life changes or losses in the past year?

Do you have any spiritual needs that require assistance?

Would you like to see a social worker or chaplain?

Do you have a living will? Living Will info given_____

What are your short term health goals?_____

What are your long term health goals?_____

Do you currently smoke? ___Yes ___No Would you be interested in FREE classes to stop smoking? ___Yes ___No

Have you been seen by any health care provider in the last 12 months including ER, Health Dept., private doctor or QuikMed™/Acute Care facility?	☐Yes ☐No	If yes, which one(s)?

Income Information:

Are you currently employed?	☐Yes ☐No	If no, last date of employment:
Your employer		
Your monthly/yearly income (before taxes)	Monthly	Yearly
Spouse or Significant Other employer	Monthly	Yearly
Spouse/Other household income (before taxes)	Monthly	Yearly
Monthly other income for household (including applicant) (VA, Unemployment, Food Stamps, Child Support, Interest, Dividends, other)	Monthly	Yearly
TOTAL INCOME	Monthly	Yearly
Do you have a military related disability and did you serve for at least 3 years?	☐Yes ☐No	If yes, you should have Veterans benefits
Do you receive Social Security disability, DIB or SSI disability?	☐Yes ☐No	
Have you had a work related injury? Is there any legal action anticipated regarding any injury or illness?	☐Yes ☐No ☐Yes ☐No	If yes, have you applied for disability?

Referral Information:

Referred by:

How did you hear about Project Access?

What doctors and/or medical services have you or do you currently receive?

Do you have an outstanding bill at ANY medical provider, including hospital? ☐Yes ☐No
If yes, to whom and what is the balance?

Appointment Information:

***Spiritual Referral*:**	**Interpreter needed:** ☐Yes ☐No **Type:**			
Referred to: (primary physician) name and address	***Best Available Days***	***Best Available Time***	**Appt date:**	**Appt time:**
Referred to: *(specialty physician)* name and address	***Best Available Days***	***Best Available Time***	**Appt date:**	**Appt time:**
Clinic eligible				

Updated 4/15/8 – 10/22/08; 03/25/09; 05/01/09; 09/25/09 11/09/09