

Date received:
Expiration date:
PJA USE ONLY

DATE: _____

RCMS Project Access, Inc. Patient Re-Enrollment/Update Application

Patient Name Social Security Number Date of Birth

Address City, State, Zip Phone

I _____, hereby apply for re-enrollment into RCMS Project Access, Inc.
Print Name

My signature below denotes understanding and agreement to items 1 - 8 below:

1. I believe that my household does not have enough income or resources to pay the charges for the medical care that I need.
2. I certify that I (the patient):
 - a. Is not covered by any health insurance plan (Medicare, Medicaid, or private insurance)
 - b. Is not receiving Cancer State Aid benefit
 - c. Is not eligible for Veteran's Administration medical care
 - d. Is not a member of the military or a military member's dependent(s)
 - e. Within the last three years, has not been convicted of welfare fraud, entered into a disqualification consent agreement, been determined at an administrative hearing to have committed an intentional welfare program violation, or have waived a disqualification hearing with respect to a charge of welfare fraud or intentional program violation
 - f. Is not a college student who is covered under his/her parent's insurance coverage
 - g. Is not an illegal alien or illegal immigrant
3. I also certify that the injury or illness for which I am asking care for did not occur while at work, is not covered by worker's compensation, is not the result of an automobile accident, and is not covered by medical coverage due to an automobile accident or any pending lawsuit.
4. I authorize employers, Social Security Administration, Veterans Administration, Departments of Social Services, Family and Children Services (DFCS), and any other State or local agency to release benefit and payroll information for the purpose of determining my eligibility for health care assistance. I understand the information I provide may be verified for completeness and accuracy to include credit reviews with credit bureaus. I specifically authorize the Department of Labor to provide earnings information to DFCS.
5. I understand that depending on the information I provide, additional requirements for assistance may be applicable, such as applying for Medicaid and/or Food Stamps. DFCS will notify me if there are any other requirements.
6. I understand that DFCS determines eligibility and that such determination/denial does not affect my ability to receive care for medically essential service at Druid Park Community Health Center.
7. I understand that I am required to be interviewed by and provide information to DFCS in order to verify and maintain eligibility, and that I have been given a copy of the information requirements.
8. I understand that if I fail to comply (i.e.. failure to keep assigned appointments, to provide required documentation, to meet given time frame requirements) or fail to provide full and true information, my application will be automatically denied, and I may not be eligible to apply for RCMS Project Access in the future.

Patient's Signature _____ Relationship to Patient _____ Date _____

Witness/Registrar _____

The re-enrollment application process takes about ten days. It is your responsibility to make sure this form is completed and returned along with all necessary verification to avoid any lapse in coverage. We ask that you do not make any future appointments until you get your new cards in the mail. Thank you again for your interest in this program.

RCMS Project Access, Inc.
Patient Re-Enrollment/Update Application

Please answer the following questions:

1. a. Have you moved or has your address changed in the last three (3) months? Yes No
b. If so please list your new address below: (Including new phone numbers)

2. a. Has your marital status changed in the last three (3) months? Yes No
b. If so please explain and select your new marital status.

Married Divorced
 Separated Widowed

3. a. Has your or any other HH Members employment status changed in the last three (3) months? Yes No
b. If so please explain and give us your updated information:

4. a. If you receive benefits from State Programs (FS, subsidize housing, TANF) are there any changes? Yes No
b. If so please explain and give us your updated information:

5. a. Has your monthly income (before taxes) changed from the amount reported on your original Project Access application? Yes No
b. If so please explain:

6. a. If you receive child support, SSI, RSDI, UCB, VA has this amount changed in the last three months? Yes No
b. If so please explain:

7. a. Have you applied for Medicare, Medicaid, Health Insurance, Disability or have you had any WC claims pending litigation due to an accident within the last three (3) months? Yes No
b. If so please explain:

8. a. Has the number of people in your home changed within the last three (3) months? Yes No
b. If so please explain:

9. a. Please explain any other changes that you may have had in your financial resources within the last three (3) months:

