ENROLLMENT APPLICATION

A COMPLETED APPLICATION AND SUPPORTING DOCUMENTS
ARE REQUIRED TO PROCESS YOUR ENROLLMENT

PATIENT INFORMATION

PATIENT'S FIRST NAME	MIDDLE INITIAL	LAST NAME		DATE OF BIRTH
GENDER/SEX ☐ FEMALE ☐ MALE	SOCIAL SECURITY NUMBER	US CITIZEN ☐ YES ☐ NO		DO YOU HAVE A PRIMARY CARE DOCTOR? ☐ YES ☐ NO
PHYSICAL ADDRESS STREET	CITY	STATE	ZIP	NAME OF YOUR PRIMARY CARE DOCTOR?
MAILING ADDRESS STREET	CITY	STATE	ZIP	ARE YOU AN ESTABLISHED PATIENT? ☐ ANCHORAGE NEIGHBORHOOD HEALTH ☐ PROVIDENCE FAMILY MEDICINE CENTER
HOME TELEPHONE NUMBER	CELL NUMBER	WORK NUMBER		WHAT IS YOUR CURRENT MEDICAL NEED?
EMAIL				ARE YOU CURRENTLY SEEING A DOCTOR FOR THIS MEDICAL NEED? ☐ YES ☐ NO
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE PARENT HEAD OF HOUSEHOLD				IF YES, NAME OF DOCTOR.
EDUCATION ☐ LESS THAN HIGH SCHOOL ☐ HIGH SCHOOL GRADUATE OR GED ☐ SOME COLLEGE ☐ COLLEGE GRADUATE				

ETHNICITY

☐ WHITE	☐ ASIAN	☐ BLACK/AFRICAN AMERICAN	☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ ASIAN & WHITE	☐ HISPANIC/LATINO	☐ ASIAN & PACIFIC ISLANDER	☐ OTHER MULTI-RACIAL
☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER	☐ BLACK/AFRICAN AMERICA & WHITE	☐ AMERICAN INDIAN OR ALASKAN NATIVE & BLACK/AFRICAN AMERICAN	☐ AMERICAN INDIAN OR ALASKA NATIVE & WHITE

EMERGENCY CONTACT	RELATIONSHIP	EMERGENCY PHONE	OTHER PHONE NUMBER
IS ENGLISH YOUR FIRST LANGUAGE? ☐ YES ☐ NO	IF NO, WHAT LANGUAGE DO YOU SPEAK?		DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO
HOUSING: ☐ OWN ☐ RENT ☐ HOMELESS ☐ STAYING WITH FRIENDS & FAMILY-HOMELESS ☐ OTHER (BE SPECIFIC):			
IF HOMELESS, WHO ARE YOU LIVING WITH?	NAME	RELATIONSHIP	PHONE
DO YOU HAVE A CASE MANAGER? ☐ YES ☐ NO	FACILITY NAME	CASE MANAGER'S NAME	PHONE
HOW LONG HAVE YOU LIVED IN ANCHORAGE? ___ YEARS ___ MONTHS		IF YOU DO NOT LIVE IN ANCHORAGE, WHERE DO YOU LIVE? _____ ____ YEARS ___ MONTHS	

TELL US ABOUT YOUR HOUSEHOLD

SELECT ONE DEFINITION BELOW DESCRIBING YOUR HOUSEHOLD (PLEASE KNOW YOU WILL BE ASKED FOR SUPPORTING DOCUMENTATION).

☐ ALL MEMBERS OF HOUSEHOLD WHO ARE RELATED AND POOLING RESOURCES ARE COUNTED AS ONE FAMILY/HOUSEHOLD.

☐ FAMILY MEMBERS LIVING IN THE SAME HOUSEHOLD ON A TEMPORARY BASIS DUE TO A HARDSHIP AND ARE RECEIVING ROOM AND BOARD WOULD BE CONSIDERED A SEPARATE HOUSEHOLD.

☐ UNRELATED MEMBERS OF A HOUSEHOLD WHO ARE SUPPORTING ONE ANOTHER FINANCIALLY ARE CONSIDERED ONE HOUSEHOLD (E.G. LIVING AS MARRIED/COHABITATION).

☐ MEMBERS OF A HOUSEHOLD WHO ARE UNRELATED AND DO NOT SHARE INCOME ARE CONSIDERED SEPARATE HOUSEHOLDS.

TELL US ABOUT YOUR HOUSEHOLD CONTINUED

NUMBER OF PEOPLE IN YOUR HOUSEHOLD _____. LIST ALL MEMBERS BELOW

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATION TO APPLICANT	SOURCE OF INCOME	MONTHLY INCOME BEFORE TAXES
PATIENT			SELF		

ELIGIBILITY QUESTIONS

1. HAVE YOU PREVIOUSLY BEEN ENROLLED IN ANCHORAGE PROJECT ACCESS? ☐ YES ☐ NO IF YES, PROVIDE DATE _____

2. DO YOU CURRENTLY HAVE ANY TYPE OF HEALTH INSURANCE, HOSPITALIZATION INSURANCE, CATASTROPHIC INSURANCE, NATIVE HEALTH SERVICES, DENALI KID CARE, TRI CARE, VA BENEFITS, MEDICARE, MEDICAID OR CAMA? ☐ YES ☐ NO IF YES, WHAT TYPE? _____
   DO YOU CURRENTLY HAVE ANY DENTAL INSURANCE FOR ORAL CARE?

3. HAVE YOU APPLIED FOR HEALTH INSURANCE THROUGH THE AFFORDABLE CARE ACT MARKETPLACE EXCHANGE? ☐ YES ☐ NO
   IF YES, WHAT WAS THE OUTCOME?
   HAVE YOU APPLIED FOR DENTAL INSURANCE THROUGH THE AFFORDABLE CARE ACT MARKETPLACE EXCHANGE? ☐ YES ☐ NO

4. HAVE YOU EVER RECEIVED HEALTH INSURANCE INCLUDING MEDICAID BENEFITS? ☐ YES ☐ NO
   IF YES, WHEN AND WHY WAS IT TERMINATED? _____

5. HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY? ☐ YES ☐ NO IF YES, DATE APPLIED _____ CURRENT STATUS _____

6. IS THERE A POSSIBILITY YOU WILL RECEIVE MEDICARE, MEDICAID OR HEALTH INSURANCE? ☐ YES ☐ NO EFFECTIVE DATE _____

7. DO YOU CURRENTLY RECEIVE ASSISTANCE FROM ANY STATE PROGRAM? ☐ YES ☐ NO IF YES, WHICH? _____
   (FOOD STAMPS, HOUSING BENEFITS, ADULT PUBLIC ASSISTANCE, ETC.)

8. PATIENT EMPLOYMENT STATUS?
   ☐ PART TIME (WORK 30 HRS OR LESS) ☐ FULL TIME (WORK 30 HRS OR MORE) ☐ UNEMPLOYED ☐ SELF EMPLOYED (OWNER OF BUSINESS)
   EMPLOYER? _____ OCCUPATION? _____

   IF UNEMPLOYED, LAST DATE OF EMPLOYMENT. _____ ARE YOU RECEIVING WEEKLY UNEMPLOYMENT CHECKS? ☐ YES ☐ NO AMOUNT $ _____

   DOES EMPLOYER OFFER MEDICAL INSURANCE? ☐ YES ☐ NO IF YES, COST OF MONTHLY PREMIUM? _____
   DOES EMPLOYER PAY A PORTION MONTHLY? ☐ YES ☐ NO EMPLOYER PORTION $ _____ EMPLOYEE PORTION $_____

   SPOUSES EMPLOYMENT STATUS?
   ☐ PART TIME (WORK 30 HRS OR LESS) ☐ FULL TIME (WORK 30 HRS OR MORE) ☐ UNEMPLOYED ☐ SELF EMPLOYED (OWNER OF BUSINESS)
   EMPLOYER? _____ OCCUPATION? _____

   DOES EMPLOYER OFFER MEDICAL INSURANCE? ☐ YES ☐ NO COST OF MONTHLY PREMIUM -EMPLOYEE $_____ SPOUSE $_____

9. IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO IF YES, HAVE YOU FILED A WORKER'S COMPENSATION CLAIM ☐ YES ☐ NO
   WHAT IS THE CURRENT STATUS?_____ ATTORNEY'S NAME _____

10. IS THERE ANY LEGAL ACTION INCLUDING CLASS ACTION SUITS ANTICIPATED REGARDING THIS INJURY OR ILLNESS? ☐ YES ☐ NO
    WHAT IS THE CURRENT STATUS?_____ ATTORNEY'S NAME _____

11. HAVE YOU BEEN SEEN BY ANY HEALTH CARE PROVIDER IN THE LAST 12 MONTHS, INCLUDING THE EMERGENCY DEPARTMENT, COMMUNITY CLINIC, URGENT CARE CLINIC OR PRIVATE DOCTORS? ☐ YES ☐ NO IF YES, LIST?

REQUIRED SUPPORTING DOCUMENTATION MUST BE INCLUDED WITH THIS APPLICATION

□ **ENROLLMENT APPLICATION** COMPLETE, SIGN AND DATE

□ **PROOF OF IDENTIFICATION** EXPIRED *ID NOT ACCEPTED*
- STATE DRIVER'S LICENSE
- STATE IDENTIFICATION CARD
- PASSPORT

AND, IF APPLICABLE
- PERMANENT RESIDENT CARD (GREEN CARD)
- EMPLOYMENT AUTHORIZATION CARD
- REFUGEE TRAVEL DOCUMENT
- STUDENT VISA

□ **PROOF OF RESIDENCY** (PROVIDE ONE) NEEDS TO SHOW PHYSICAL ADDRESS (NO PO BOX ADDRESS)
- UTILITY BILL SUCH AS ELECTRIC, GAS, WATER, CELL PHONE BILL, MEDICAL BILL
- RENTAL AGREEMENT OR MORTGAGE STATEMENT
- IF YOU LIVE WITH A FRIEND OR RELATIVE A WRITTEN STATEMENT OF YOUR RESIDENCE WITH HIS/HER SIGNATURE AND CONTACT INFORMATION

INSURANCE DOCUMENTATION: *SEE RESOURCE SHEET FOR MORE INFORMATION*

☐ **MEDICAID**–FAMILY OR INDIVIDUALS BETWEEN 19 TO 64 YEARS OLD WITHOUT DEPENDENT CHILDREN MAY QUALIFY FOR BENEFITS
- DID PATIENT APPLY FOR MEDICAID?
  - ☐ YES, PROVIDE DOCUMENTATION SHOWING DETERMINATION
  - ☐ NO

☐ **MEDICARE**–INDIVIDUALS 65 YEARS OR OLDER MAY QUALIFY FOR BENEFITS
- DID PATIENT APPLY FOR MEDICARE?
  - ☐ YES, PROVIDE DOCUMENTATION SHOWING DETERMINATION
  - ☐ NO

☐ **ACA MARKETPLACE INSURANCE**–(HEALTHCARE.GOV)
- DID PATIENT APPLY FOR MARKETPLACE INSURANCE?
  - ☐ YES, PROVIDE DOCUMENTATION SHOWING DETERMINATION
  - ☐ NO

☐ **INDIAN HEALTH BENEFITS**–AMERICAN INDIAN, ALASKA NATIVES MAY QUALIFY FOR HEALTH BENEFITS
- IS PATIENT A BENEFICIARY OF INDIAN HEALTH BENEFITS?
  - ☐ YES, HAS CDIB (CERTIFICATE OF DEGREE OF INDIAN BLOOD)
  - ☐ NO, WILL NEED DENIAL LETTER

☐ **EMPLOYER SPONSORED INSURANCE**-INSURANCE MAY BE AVAILABLE THROUGH INDIVIDUAL'S JOB
- IS PATIENT (AND/OR SPOUSE) EMPLOYED FULL/PART TIME? ☐ YES-PATIENT ☐ NO-PATIENT ☐ YES-SPOUSE ☐ NO-SPOUSE

IF **EMPLOYED**, A LETTER IS REQUIRED FROM THE EMPLOYER TO DETERMINE IF PATIENT QUALIFIES FOR AN EMPLOYER-SPONSORED INSURANCE PLAN. LETTER MUST BE WRITTEN BY AUTHORIZED PERSONNEL ON COMPANY LETTER HEAD TO INCLUDE HIS/HER NAME AND CONTACT NUMBER & THE FOLLOWING:

- EMPLOYMENT START DATE
- HOURS WORKED
- WAGES EARNED
- IS INSURANCE OFFERED TO EMPLOYEE AND SPOUSE
- DATES OF NEXT INSURANCE OPEN ENROLLMENT PERIOD
- COST OF PREMIUM FOR BOTH EMPLOYEE AND SPOUSE (EMPLOYEES PORTION AND EMPLOYER'S PORTION IF APPLICABLE)

IF PATIENT, SPOUSE AND/OR OTHER APPLICABLE HOUSEHOLD MEMBER ARE EMPLOYED

□ CURRENT YEAR TAX RETURN (1040, 1040A, 1040EZ)- IF YOU DID NOT FILE TAXES IT MUST BE STATED IN A LETTER OF CIRCUMSTANCE WHY NOT FILED
□ ALL INCOME PAY STUBS FOR THE LAST THREE MONTHS
□ COMPLETE BANK STATEMENTS FOR THE LAST THREE MONTHS (CHECKING & SAVINGS ACCOUNTS) -IF NO ACCOUNTS, STATE IN A LETTER OF CIRCUMSTANCES
□ RETIREMENT, PENSION OR INVESTMENT ACCOUNT STATEMENTS - IF NONE, MUST BE STATED IN A LETTER OF CIRCUMSTANCES
□ LETTER OF CIRCUMSTANCES- DETAILS EXPLAINING CURRENT FINANCIAL AND LIVING SITUATION

IF CURRENTLY RECEIVING UNEMPLOYMENT, SOCIAL SECURITY INCOME (SSI) OR OTHER INCOME

□ ALL OF THE ABOVE DOCUMENTS (TAXES, BANK STATEMENTS, RETIREMENT OR INVESTMENT ACCOUNTS)
□ DETERMINATION LETTER FROM APPROPRIATE AGENCY
□ LETTER OF CIRCUMSTANCES- DETAILS EXPLAINING CURRENT FINANCIAL AND LIVING SITUATION

IF YOU ARE CLAIMING ZERO INCOME

□ ALL OF THE ABOVE DOCUMENTS (TAXES, BANK STATEMENTS, RETIREMENT OR INVESTMENT ACCOUNTS)
□ A ZERO INCOME CERTIFICATION FORM
□ LETTER OF CIRCUMSTANCES- DETAILS EXPLAINING CURRENT FINANCIAL AND LIVING SITUATION

IF PATIENT/SPOUSE ARE SELF-EMPLOYED (INCLUDES INCOME FROM RENTAL PROPERTY AND INVESTMENTS)

□ CURRENT YEAR TAX RETURN (1040 WITH SCHEDULE C –PROFIT OR LOSS FROM BUSINESS)
□ BUSINESS AND PERSONAL BANKS STATEMENTS FOR THE LAST THREE MONTHS (CHECKING & SAVING ACCOUNTS)
□ RETIREMENT, PENSION OR INVESTMENT ACCOUNT STATEMENTS - IF NONE, MUST BE STATED IN A LETTER OF CIRCUMSTANCES
□ LETTER OF CIRCUMSTANCES- DETAILS EXPLAINING CURRENT FINANCIAL AND LIVING SITUATION

I HEREBY AUTHORIZE REPRESENTATIVES OF ANCHORAGE PROJECT ACCESS TO MAKE ANY INQUIRIES NECESSARY TO VERIFY THE INFORMATION ON THIS FORM. I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, THE INFORMATION GIVEN ABOVE IS TRUE AND COMPLETE. I UNDERSTAND THAT IF ANY INFORMATION IS FOUND TO BE INCORRECT, I MAY BE CHARGED BY HEALTH PROVIDERS FOR SERVICES I HAVE RECEIVED THROUGH ANCHORAGE PROJECT ACCESS.

SIGNATURE _____ DATE _____

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