INSTRUCTIONS: Patient please read, sign and return to Anchorage Project Access (APA).

No one is being paid for the healthcare you receive. Health care/dental providers and many others are volunteering their services to help you get and stay well. This is NOT insurance or a government entitlement program. We CANNOT guarantee that you will not be billed for some of your services. Though it is not our intention, our help may end at any time for any reason. Your responsibilities, the assistance available and other conditions may change at any time. By signing this form or by using your APA card in any capacity you agree to comply with the responsibilities below and you authorize APA to verify your information with state and other agencies. Patients should understand that we can only offer services as they are donated. We cannot guarantee specific services or the length of specific wait times before a patient is able to see a health care/dental provider.

NOTE: Hospital services, anesthesia, lab services, emergency department visits, ambulance services, specific dental, durable medical equipment, or vision hardware costs are not provided by this program. You will be expected to pay for these services if you need them. Only services from participating health care/dental providers are available through this program.

Patients who anticipate legal action regarding this injury or illness are not eligible for help through APA.

ANCHORAGE PROJECT ACCESS ACCEPTS THE FOLLOWING RESPONSIBILITIES:

- Assisting you in finding a health care/dental provider
- Assisting you in getting low cost medications
- Listening and understanding the needs of our volunteer providers
- Listening and understanding patient needs and concerns
- Facilitating, when necessary, between the patient and the provider
- Arranging and documenting a patient’s primary care “home”
- Arranging and documenting a patient’s specialty consultation
- Arranging, documenting, and reminding patients about their initial visits with primary care and specialty providers

AS AN ANCHORAGE PROJECT ACCESS PATIENT YOU ACCEPT THE FOLLOWING RESPONSIBILITIES:

GENERAL
You agree that you:

- Will not schedule appointments with any provider, clinic or hospital other than follow-up medical appointments with the providers APA has connected you with for donated services.
- Will follow your treatment plan, for example: get prescribed medicines and take as directed. If you cannot afford your prescription call us.
- Will apply for financial assistance with hospitals when instructed to by APA staff.
- Will adhere to APA pharmacy guidelines.
- Will promptly supply any information requested by the APA program staff.
- Will allow all information regarding your participation in this program to be shared with other individuals, organizations and agencies solely at the discretion of APA.
- Will immediately contact APA if your income changes or if you become covered by Medicare, Medicaid or private health/dental insurance.
- Will apply for Medicaid or other assistance programs if eligible.
- Will contact APA immediately with any changes in your address or phone number.
PATIENT RESPONSIBILITY FORM, CONT’D

- Will return APA calls and other communications promptly (within 24 hours).
- Have read the eligibility guidelines, understand them, and agree to follow them
- Abusive behavior will not be tolerated to providers, their staff and/or staff at APA and can be cause for dismissal.
- You or a family member will participate in at least 20 hours of volunteer service for medical services. Dental community service will vary; your APA patient care coordinator will advise you.
- Will participate in our initial and follow-up health surveys.
- Will consider sending a thank you note to all providers who assisted in your care.

REFERRALS/APPOINTMENTS
You agree that you:

- Keep each provider’s appointment. If you miss one (1) appointment without canceling at least 24 hours in advance (or whatever time your provider requires), you will be dropped from the program.
  - If you need to cancel an initial provider visit, please contact your APA patient care coordinator who will reschedule the appointment for you.
- Do not cancel or re-schedule your appointment without a valid reason – e.g. family emergency; jury duty. If you cancel or reschedule an appointment without a valid reason, you will be dropped from the program.
  - If you have a valid reason to cancel or re-schedule a follow-up appointment with a provider, please do so at least 24 hours in advance (or whatever time your provider requires.)
  - Sleep study cancellations are at the discretion of the provider. If you cancel without 24-hour notification you may be billed.
- Present your APA ID card each time you see a health care/dental provider.
- The goal of this program is to transition you away from emergency care if you currently use the hospital Emergency Department for your primary care needs. Please use these facilities only in true medical emergencies. Emergency Department costs are NOT provided by this program. Please report to your APA patient care coordinator when you have visited the Emergency Department for our tracking purposes. Part of our funding relies on tracking this data and we appreciate your understanding and assistance.
- Be patient. Understand that the services we offer are those donated through area health care/dental providers and, given the need, there may be a wait period until you get an appointment. In addition, we may not be able to provide the full spectrum of services in each area, because they are not donated.

MEDICATION ASSISTANCE
You understand that:

- There is a 12-month maximum coverage of $800 (January through December calendar year).
- There is no prescription assistance for dental services.
- Most types, but not all medications, are available through this program. Your provider may be contacted and asked to use medications available through the program.
- A pharmacy may stop participating at any time, for any reason.
- $5 co-pay per prescription may be required by your pharmacy.
- You are to present your pharmacy card each time you have a prescription filled.
- Pharmacy benefits are for current medical treatment/s under APA only; misuse of these benefits may result in termination from the project.

I have reviewed and understand the Patient Responsibility Form and agree to follow these guidelines.

____________________________  ______________________________  ______________
Patient Name Printed                  Patient Signature                                               Date