Project Success Ministries Inc.
HELPING THOSE IN NEED

Application for Eligibility

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Race: _____ Ethnicity (circle): Hispanic Non-Hispanic

County of Residence: _____

Income

Are you currently working? (circle) NO YES

Total income per month (include all sources -job, SSI, food stamps, etc.): _$_____

How many people are in your household? (circle)

1 2 3 4 5 6 7 8 9 Other____

Insurance

Do you have Medicare? (circle) **NO** YES IF YES, Part A Part B

Do you have Medicaid? (circle) **NO** YES IF YES, Full Medicaid Family Planning Only

Do you have VA benefits? (circle) NO YES

Do you have Private Insurance? (circle) **NO** YES IF YES, Company Name: _____

Are you currently seeing a doctor? (circle) NO YES IF YES, Doctor Name: _____

Patient Financial Assistance Application

Date: _____

Patient Information

Name: _____ _____ SOCIAL SECURITY#:_____
(Last) (First) (MI)

Marital Status: Married__) Single__) Divorced__) Widowed__) Separated__

How long have you lived in Alabama? _____ D/O/B: _____/_____/_____
(mm/dd/yyyy)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____ _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (___) _____ (_) _____ (__) _____
(Home) (Work) (Cell)

Email address _____ Can we text you at your cell number? _____ _

Responsible Party Information (If patient is under 19 years of age.)

Name: _____ __ D/O/B: _____/_____/_____
(Last) (First) (MI)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (___) _____ _____ (___) _____
(Home) (Work) (Cell)

Relationship to Patient: _____ _ SOCIAL SECURITY#:_____

List all persons to be included in application process: *Please read instruction on the cover letter of the Financial Assistance Application packet before completing this section and ensure that you provide Annual Income of all earning family members.*

	Name	DOB	SS#	Annual Income
Applicant				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

(Please list any additional legal dependents along with proof such as court order on separate sheet if applicable.)

Patient Financial Assistance Application

(Please Print)

Name: _____ (Lui) _____ (First) ___ (MI)

Please ensure that you provide proof of all information that you input in the sections below under Income, Assets, and Governmental Programs/ support. Please input N/A against items that do not apply to you.

INCOME			ASSETS	
Description	Monthly Income		Description	Value Amount
Gross Salary for Applicant	$		Home (Recent Appraised Value)	$
Employer Name:			Checking Account (Provide Current Month's statement)	$
Gross Salary for Spouse	$		Name of Bank(s)	
Employer Name:			Savings Account (Provide Current Month's statement)	$
Gross Salary for any other Family member less than 18 years of age	$		Name of Bank(s)	$
Gross Salary for any other Family member over 18 years	$		IRA (Provide copy of certificate)	$
Dividend and Interest	$		Other	$
Rental Income	$		TOTAL ASSETS	$
Pension Income	$			
Alimony (Income)	$		Complete if you do not show income or assets	
Social Security Benefits	$		Food Stamps	
V.A. Benefits	$		Housing subsidy	
Income from estates, trusts	$		HUD	$
			Section 8	$
Other-	$		Utilities	$
TOTAL INCOME PER MONTH	$		Help from relative, friends, or others to cover expenses such as Rent, Car, Apartment etc.	$

I provide my consent and understand that the information I submit is subject to verification by Project Success and subject to review by state and/or federal enforcement agencies, and other entities as required by law. I also understand that Project Success reserves the right to ask for additional information.

I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for medical care rendered to the above patient. If my financial situation changes in the upcoming calendar year, I will report these changes to the Project Success immediately.

***My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, I will provide Project Success with this information and understand that if I choose not to give any information regarding my supplemental insurance carrier, my application for assistance could be denied and I will be responsible for the total amount of all outstanding bills at Project Success. I read and understand what is not covered by financial assistance and I cannot request a further review/audit of my charges once financial assistance is approved.**
***Financial Assistance does not include Medications prescribed for patients to self-administer upon discharge.**

I give Project Success permission to email me (if email is provided) my approval/denial letter.

Signature of Responsible Party: _____ Date: _____

Patient Financial Assistance Application

(Please Print) Name: _____ (last) (First) (MI)

Insurance Information:

Do you or your spouse have health insurance (Yes___ /No___)? If so, list below:

	Insurance Company	Policy#	Group#
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Is health insurance available to you through your employers? Yes__ No__ N/A__ _

Have you declined health insurance coverage offered to you by your employer or through responsible person's employer? Yes__ No__ N/A__

Have you received or do you expect to receive a Third Party Liability settlement related to an accident or injury resulting in your admission to Baptist Health? Yes__ No

If your visit at Baptist Health is the result of an accident or injury, are you represented by an attorney? Yes__ No

If "Yes," please complete the following:

Attorney Name:_____

Attorney Address: _____

Attorney Telephone: _____

My signature below attests that the above information is valid and true.

Signature of Responsible Party: _____ Date:_____

Patient Financial Assistance Application
(Please Print)

Name: _____ _____ ___
(Last) (First) (MI)

Financial Assistance does not cover the following services:

- Copays
- Reconstructive surgery which is not medically necessary
- Cosmetic surgery
- Breast implants
- Breast reduction
- Teeth extractions (excluding radiation, transplant patients or extractions due to trauma.)
- Weight loss surgery
- Genetic testing that is required for determining treatment will be covered, but all other genetic testing will be charged to the patient.
- Medications prescribed for patients to self-administer upon discharge.
- Durable medical equipment
- Routine Physical Exams
- Services not normally covered by health insurance

These are examples of services not covered under Financial Assistance Program. This list may not include all exclusions to the program.

Should you have questions regarding your particular plan of care, please feel free to call our office at (866)690-0007.

We reserve the right to change or update covered or non-covered services without notice.

My signature below verifies that I have read and understand the list and statements stated above.

Signature of Responsible Party: _____ **Date:** _____

Medical History

Please answer these questions so we can help you be **as healthy as you can be.**

Name: _____

Today's Date: _____

Date of Birth: _____

Social Security Number: _____

Occupation· _____ Last Grade Completed in School _____ Married· Single·

LIST ANY DRUG ALLERGIES

LIST CURRENT MEDICATIONS, including those not prescribed by a doctor

( ) I/you n u d more space, check here and list your other medications on another oiece ofoaoer.

FAMILY HISTORY

Please check the box to the right i fany family member has had the following:	Father	Mother	Father's Parents	Mother's Parents	Other
Heart disease					
High blood pressure					
Stroke					
Cancer					
Glaucoma					
Diabetes					
Epilepsy/convulsions					
Bleeding					
Kidney disease					
Thyroid disease					
Mental Illness					
Osteoporosis					

HOSPITALIZATIONS OR SURGERIES

Reason	*Date*	*Reason*	*Date*

WOMEN ONLY: Are you pregnant? ( ) Yes ( ) No Are you planning a pregnancy? ( ) Yes ( ) No

Date of your last mammogram: _____ _ Date of your last Pap smear: _____ _

YOUR PERSONAL MEDICAL HISTORY

Check all that apply. I fyou have diabetes, please complete the back of this form.

( ) Headaches
( ) Shortness of breath
( ) Heart palpitations
( ) Heart murmur
( ) Chest pain
( ) Dizziness *I* fainting
( ) Peripheral vascular disease
( )Allergies/ hay fever
( ) Asthma
( ) Bronchitis
( ) Pneumonia
( ) Ulcer
( ) GI disorder
( ) Early morning awakening
( ) Daytime drowsiness
( ) Difficulties Sleeping

( ) Lactose intolerance
( ) Gallbladder disease
( ) Renal disease
( ) Prostate disease
( ) Bowel irregularity
( ) Incontinence
( ) Sexual / menstrual dysfunction
( ) Venereal disease
( ) Frequent infections
( ) Hepatitis
( ) Anemia
( ) Arthritis
( ) Osteoarthritis
( ) Hearing loss
( ) Problems with reading or vision loss

( ) Nervousness
( ) Depression
( ) Gout
( ) Scarlet fever
( ) Chronic rashes
( ) Rheumatic fever
( )AIDS/HIV
( ) Past stroke
( ) Diabetes - SEE BACK OF FORM
( ) Past heart attack
( ) Date of last tetanus shot:
( ) Date of last flu shot:
Date of last neumonia vaccine:

Do you smoke? ( ) Yes ( ) No
How long have you smoked? _ _ Years
How many packs per day? _ _
Are ou interested in uittin ?

Do you drink? ( ) Yes ( ) No
How many days per week? _ _
( ) Beer ( )Wine ( ) Liquor
How man drinks at a time?

What exercise do you enjoy?

How often do you exercise?

What prevents you from exercising?

Transportation: ( ) Drive my own car ( ) Family/ friends drive me ( ) Walk ( ) Bus ( ) Other

Other health questions or concerns:

COMPLETE THE NEXT PAGE IF YOU HAVE DIABETES

Diabetes Update

If **you have diabetes,** please complete this page before seeing your doctor.

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Have you been told by a doctor you have diabetes? ( ) Yes ( ) No If yes, when? _____
What type of diabetes do you have? ( ) Type 1 ( ) Type 2 ( ) Don't know

Please list all diabetes medicines you are taking.		

Do you feel your diabetes medicines are working properly? ( ) Yes ( ) No

What was your most recent A1C level? _____ ( ) Don't know

Circle any of these tools you have for managing your diabetes:	Medicine	Blood sugar monitoring machine / strips	Insulin
	Syringes		Lancets
	Family support	Friend support	Church support
	Understanding of diabetes	Blood sugar diary	An eating plan I enjoy

Would you like to learn more about managing your diabetes? ( ) Yes ( ) No

In the past 12 months, have you seen or been to:	Number of Visits	Reason
Primary doctor		
Emergency room		
Overnight hospital stays		
Eye doctor		
Foot doctor		
Diabetes education class or counseling		

What was your most recent fasting blood sugar at home? _____ ( ) Don't know

When do you check your blood sugar? Circle ***all*** the ones that apply to you.	I do not check it	Before meals
	Before an insulin shot	Whenever I think about it
	At bedtime	Twice a day
	Other _____	

Do you have strips to check your blood sugar? ( ) Yes ( ) No
Would you like to learn more about checking your blood sugar? ( ) Yes ( ) No

When your blood sugar is low, what do you do?			
What health concerns would you like to discuss today?	**( ) Diabetes**	**( ) Weight**	**( ) Cholesterol**
	( ) Blood pressure	**( ) Eyes**	**( ) Kidneys**
	( ) Tingly feet / hands	**( ) Depression**	**( ) Sexual problem**
	( ) Frequent infection	**( ) Foot problem**	**( ) Stomach problem**

Circle your eating plan.	No eating plan	Count carbohydrates
	"See food" plan (I eat the food I see!)©	I would like to learn about eating better
	Drink lots of fluids	Other
What is the hardest thing about having diabetes?		