



Today's Date _____ **Patient Application**

Name: _____ Social Security #: _____
(First, Middle, Last)

Street Address: _____ Apt #: _____

P.O. Box: _____

City/State/Zip: _____ Years/Months at Current Address: _____

Telephone: _____ Cell: _____ Email: _____

Date of Birth: _____ Age: _____ Number of People living at Current Address: _____

Gender: Male Female Which county are you a resident of? _____

Ethnicity: African American Caucasian Hispanic Asian Native American Other: _____

Marital Status: Single Married Separated Divorced Widowed

Education Level: Less than High School GED High School Graduate

Some College College Graduate

Housing: Rent Own Home Homeless Other: _____

Primary Language: _____ Speak English? Yes No

Emergency Contact: _____ Phone: _____

Relationship to Contact: _____

Have you applied for TennCare? Yes No Approximately Last date applied: _____

If yes, what was the result from your TennCare application? _____

Are you currently covered by any Health Insurance, Medicare, or TennCare? Yes No

If yes, please list name of health coverage: _____

Is Health Insurance available through your current employer? Yes No

If yes, Monthly estimated cost of insurance to you \$ _____

Have you ever received Health Insurance benefits, including TennCare? Yes No

If yes, when and why was it terminated? _____

Is there a possibility you will receive Medicare, TennCare, or Health Insurance? Yes No

If yes, please explain: _____

Do you receive any type of disability benefits? Yes No If yes, what type?_____

Have you applied for disability? Yes No Status:_____

Do you currently receive assistance from any State Programs? Yes No
If yes, what type?_____

Do you receive food stamps? Yes No

Did you ever serve in the US Military? Yes No
If yes, number of years of service?_____ Discharge status:_____

Are you eligible for VA benefits? Yes No

Have you ever been treated for work-related and/or Motor Vehicle Accident-related injury?
Yes No If yes, what injuries did you receive in the work-related or Motor Vehicle Accident?

_____ Date of injury:_____

What is the status of your Worker's Compensation and/or Accident Insurance claim(s)?

Is there any legal action anticipated regarding this injury or illness? Yes No

Will your injury or illness prevent you from working for 12 months or longer? Yes No

Please provide information for every person living at your current address:

Name	Age	Employer	Hours Worked/Week	Rate of Pay

Do you or anyone living at your current address own a business? Yes No
If yes, who?_____ Type of business_____ Years in business _____

Do you currently have a primary care physician? Yes No
If yes, who/what practice?_____

Current Medical Problems_____

Checking Account # _____ Bank _____

Current Balance: \$ _____ Is this your only checking account? Yes No

Savings Account # _____ Bank _____

Current Balance: \$ _____

Monthly Household Income (Total for everyone at your residence):

Social Security	Child Support	Unemployment	Disability

Pension/Retirement	Rental Property	Welfare	Food Stamp Allotment

Alimony	Salary/Wages	Cash Assistance	

Monthly Household Expenses (Total for everyone at your residence):

Mortgage/Rent	Car Payment	Car Insurance	Electric

Water	Gas	Groceries	Medication

Telephone	Cell Phone	Cable/Satellite TV	Property Taxes

Home Owner's Insurance	Medical Insurance

How did you hear about Project Access? _____

I certify that the above information is true to the best of my knowledge and there is no intent to commit fraud. I understand that appropriate action will be taken if the above information is misrepresented. I understand that eligibility for this program must be evaluated and will be confirmed by mail to the applicant. Further, I understand that the assistance is donated by volunteer providers and could end due to lack of volunteer services.

Patient Signature: _____ Date: _____

If you have any questions, contact the Knoxville Area Project Access office at (865) 531-2766.