KNOXVILLE AREA PROJECT ACCESS
A Program of the Knoxville Academy of Medicine

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: ☐Black ☐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.**