access health
SPARTANBURG

As part of our eligibility requirements, all AccessHealth/Healthy Outcome Program participants must recertify each year. If you would like to continue as a participant in our program, please gather the following information/documents in order to complete the recertification process.

- ☐ All forms need to be completed in black or blue ink
- ☐ $20.00 Recertification fee (***cash or money order ONLY***)
- ☐ Proof of residency:
  - ANY piece of mail with your name & physical address on it (***Not hand-written)***
- ☐ Proof of Income for **<u>ALL Adults</u>** Living in Household:

| Household Member | Name and DOB | Form of Income (Paycheck, Disability, Child Support., SS, etc.) | Total Income Before Taxes/How Often (Weekly, Biweekly, Monthly) |
|---|---|---|---|
| Self | | | $ / |
| Mother | | | $ / |
| Father | | | $ / |
| Friend | | | $ / |
| Other | | | $ / |

  - **<u>If Employed:</u>**
    - Paystubs to show earnings from the last month **ALL Employed Adults in the Household**
    - If you do not receive paystubs, please ask an AccessHealth staff member what documentation is required
  - **<u>If NOT Employed:</u>**
    - Current Disability Award Letter
    - Current Social Security or (SSI) Supplemental Security Award Letter
    - Unemployment Statement
    - Retirement Statement
    - Welvista "No Income and Verification of Address" form **(Only Completed if NO Household Income)**
- ☐ Current SNAP Award Letter or SC EBT card (can obtain a copy of the letter from the DSS office located at 630 Chesnee Hwy.)
- ☐ All Forms in this Packet should be Completed, Signed, and Dated
- ☐ Bring back to the office your completed packet, requested documents, and recertification fee

Please do not hesitate to call our office if you have any questions. We look forward to a continued relationship with you in maintaining good health.

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

| ______________________________ | ____________ | ______________ |
|---|---|---|
| Patient's Full Name | Date of Birth | Medical Record Number if known |

I authorize AccessHealth Spartanburg Inc., (AHS), AHS's Healthy Outcomes Initiative Partners, including, Spartanburg Regional Healthcare System, Spartanburg Area Mental Health Center, The Forrester Center, St. Luke's Free Medical Clinic, ReGenesis Health Care Inc., Emerge Family Therapy and any primary health care provider that provides/has provided primary health care services to me from January 1, 2011 to December 31, 2021 (collectively, the "Providers") to disclose the following Protected Health Information (PHI) to the South Carolina Department of Health and Human Services (SCDHHS) and the South Carolina Office for Research and Statistics (ORS):

- All of the PHI which is contained on a claim form UB-04 CMS-1450 or CMS-1500 which generally includes, but is not limited to, my name, the insured's name, address, social security number, date of birth, gender, employer, provider's internal office account number, medical/health record number, billing type code (first claim/continuing claim/final claim), dates and times of service, diagnosis codes identifying my principal diagnosis and other diagnoses, procedure codes identifying procedures provided, charges; and
- All of the PHI produced as a result of an assessment of social factors impacting my health care and my self-care behaviors that gauges my knowledge, skill and confidence in managing my own health and healthcare and an assessment of my behavioral health status.

The dates of care to be disclosed are from January 1, 2011 through December 31, 2021.

The purpose of the disclosure of PHI to SCDHHS and from ORS to SCDHHS is solely for the evaluation of the population-based activities relating to improving health and reducing health care costs set forth in the SCDHHS' Healthy Outcomes Plan.

**I UNDERSTAND THAT:**

- There will be no fee for processing this request.
- The PHI used or disclosed under this authorization may be subject to re-disclosure by the receiver and no longer protected by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and the Standards for Privacy of Individually Identifiable Health Information.
- Treatment, payment, enrollment in a health plan or eligibility for benefits may not be conditioned on whether I sign this authorization.
- If I have any questions about the disclosure of my PHI, I can contact representatives of AccessHealth Spartanburg, Inc. at **(864) 560-0190**.
- I may revoke this authorization in writing except to the extent that the Providers have previously used or disclosed the PHI in reliance on this authorization. To revoke this authorization, I understand that I must deliver a signed written statement clearly stating that I revoke this

authorization to: **AccessHealth Spartanburg Inc.**
**501 Howard St Suite B**
**Spartanburg, SC 29303**

- This authorization expires at the conclusion of the Healthy Outcomes Initiative.

| ______________________________ | ______________________________ | ____________________ |
|---|---|---|
| Authority or Relationship of Personal Representative (Attach copy of documentation of authority if applicable) | Signature of Patient or Personal Representative/Guardian | Witness<br><br>____________________<br>Witness (verbal phone authorization only) |

____________________________________ Date_________________________
Name and Title of [Hospital Name] Names of [Hospital Name]'s Healthy Outcomes Initiative Partners][Safety Net Provider]'s Employee authorized to disclose the requested PHI.

# Client Consent for the AccessHealth Spartanburg, Inc

**What is AccessHealth Spartanburg?**
We are a new grant funded program. Our goal is to coordinate care for low-income uninsured residents of Spartanburg County. We know that wellness involves more than just the treatment of an illness. As our client, we therefore hope to work with you to assess all your needs and barriers to care to achieve a network of care that will enable you to reach your goals.

**What is involved?**
First you will meet with our Eligibility Specialist to intake all your information and determine your qualification for state and federal assistance programs as well as local programs. Then you will meet and be supported by our Care Navigators, a registered nurse and social worker, to assist you in coordinating an individualized plan of care. As part of this plan of care we hope to provide you with a primary care home and referral services as needed for medical and social needs.

**What about privacy?**
Except as required by law or as you authorize, information you share with our staff is confidential and will not be released in any way that could be identifiable with you. By your signature below, you are authorizing us to share medical or other information about you and your family to assist you in obtaining placement for medical or community care and/or services. This information may include, but is not limited to, any history of psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV. By signing below, you also agree to the release of medical or other information about you to state and/or federal governmental regulatory agencies as may be required by law. You also authorize the release of your identifiable medical and other information for purposes of research specifically and without limitations to the South Carolina Office of Research and Statistics.

**What are my rights?**
Being in the program is voluntary, and you may leave the program at any time and revoke this authorization to release your medical and other information at any time by mailing or delivering a written revocation to the following address: AccessHealth Spartanburg, Inc., ATTN: Director, 501 Howard St Suite B, Spartanburg, South Carolina 29303.

**Who do I call if I have questions or concerns?**
If you have any questions or concerns, please call our office at (864) 560-0190 or you may come by our office. We are located at 501 Howard St Suite B, Spartanburg, South Carolina 29303.

**Signatures:**
Your signature means that you have decided to be part of AccessHealth Spartanburg. You will get a copy of this consent form for your personal records.

__________My initials show I had a chance to ask questions about being in the program, and that my questions were answered.

| ________________________________ | ___________________________ | ___________ |
|---|---|---|
| Participant's Signature | Participant's Printed Name | Date |

## AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name:_________________________________________ Date of Birth: ___________________

Client Address:______________________________________________________________________

SS #: ___________________________________________ Phone #: ____________________________

Emergency Contact: _______________________________ Phone #: _________________________

The undersigned hereby authorizes AccessHealth Spartanburg to release confidential information to one or more of the following: South Carolina Office of Research and Statistics, Spartanburg Regional Healthcare System, Mary Black Health Care, Social Security Administration, Department of Social Services, Spartanburg Area Department of Mental Health, South Carolina Vocational Rehabilitation, South Carolina Employment Commission, Spartanburg Alcohol and Drug Abuse Commission, Welvista, DHEC Region Two, and offices of physicians or providers for whom I have received care

Type of Information disclosed: enrollment in, participation in, and client care progress and past or present medical or other information about you and your family to assist you in obtaining placement for medical or community care and/or services. This information may include, but is not limited to, any history of psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV. By signing below, you also agree to the release of medical or other information about you to state and/or federal governmental regulatory agencies as may be required by law. You also authorize the release of your identifiable medical and other information for purposes of research specifically and without limitations to the South Carolina Office of Research and Statistics.

The purpose of the release of confidential information: to facilitate achievement of client care goals. Being in the program is voluntary, and I understand that I may leave the program at any time and revoke this authorization to release medical and other information at any time by mailing or delivering a written revocation to the following address: AccessHealth Spartanburg, Inc., ATTN: Director, 501 Howard St Suite B, Spartanburg, South Carolina 29303.

**I understand that I may refuse to sign this authorization. I understand that client information is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) federal regulations on patient privacy and confidentiality, and cannot be disclosed without my written consent unless otherwise provided for by applicable law. I am entitled to review or receive a copy of the information for which the authorization is being sought. I will receive a copy of the signed authorization. I may revoke this consent in writing at any time. This authorization expires:**

□ **one (1) year from date of signature, or:**

□ ______________________________________________________________________________

**(Specify event or condition)**

_____________________________________________ ________________________

(Client Signature) (Date)

_____________________________________________ ________________________

(Witness Signature) (Date)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Client ____________________ Date of birth ____________ Social Security # ____________

Street Address ____________________ City, State, Zip ____________________

I hereby authorize
Physician/medical facility:________________________
Fax:__________________ Phone:__________________

Physician/medical facility:________________________
Fax:__________________ Phone:__________________

Physician/medical facility:________________________
Fax:__________________ Phone:__________________

Physician/medical facility:________________________
Fax:__________________ Phone:__________________
to disclose the following information to AccessHealth Spartanburg:
Date(s) of service: ______________________________

**Disclose my protected health information to:**
**AccessHealth Spartanburg**
**501 Howard St Suite B**
**Spartanburg, SC 29303**
**Phone: (864) 560-0190**
**Fax: (864) 560-7198**

- ❑ Brief Summary of Care/discharge summary
- ❑ History & physical examinations
- ❑ X-ray reports
- ❑ Laboratory reports
- ❑ MD/Nurse progress notes
- ❑ EKG/EEG
- ❑ Face Sheet
- ❑ Cytology
- ❑ Consult(s)
- ❑ Operative Note/Pathology Report
- ❑ ED record (and attachments)
- ❑ Other:___________________

1. I understand that these records will relate to my identity, prognosis, and diagnosis.
2. I understand that signing this form will authorize the release of sensitive information (including psychiatric care, behavioral medicine, sickle cell anemia, HIV/AIDS, or treatment for substance/alcohol abuse) from the above named doctor and/or facility. I also understand that the above named doctor and/or facility will only release information relevant to Accesshealth's needs unless disclosure is permitted by law.
3. I understand that this authorization may be revoked by writing AccessHealth Spartanburg at any time at the above address, except to the extent that action has been taken to the reliance of this authorization. Unless otherwise revoked, this authorization will expire one year from the date of signature.
4. I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and will no longer be protected by privacy rules.
5. I release the above facility, its employees, and physicians for any legal responsibility or liability for this disclosure to the extent indicated and authorized.

Signature of Client ______________________________________ Date:___________

Witness ______________________________________________ Date:___________

## Client Responsibilities

**Program Overview:**

Doctors, hospitals and other providers have donated their services to help you get well and stay well. Please note that the availability of services depends on volunteer physicians and could end due to lack of volunteer services. Your responsibilities, the assistance available and other conditions may change at any time. By signing this form, you agree to comply with the Client Responsibilities below, and you authorize AccessHealth Spartanburg (AHS) to verify what you have reported during the application process. Clients who anticipate legal action regarding an injury or illness are not eligible for help through AHS. We reserve the right to require that you pay for any assistance you may receive based on inaccurate information provided by you. You may also receive some bills, for which you are responsible, should you need services not currently being donated for by the AHS program. For clients who are in the disability process or anticipate filing for disability it is understood that AHS volunteer physicians will not sign-off on any paperwork regarding disability and therefore their disability claim must be a separate process. However we are still able to offer those clients the care that they might need apart from the disability claim.

Independent Status of Providers: You understand and agree that AccessHealth Spartanburg, Inc. is assisting you in coordinating care and attempting to locate the appropriate medical and/or social provider for you, but it is not itself providing or furnishing any other or medical services to you. The actual physicians, practices, governmental or other support organizations with which AccessHealth Spartanburg, Inc. coordinates your care are not employees or agents of us, and we are not responsible for their acts or omissions.

**You agree that you:**

1. Will schedule your AHS appointments through the AHS office. Referrals to a specialist will be made based on your primary care physician's recommendations.
2. Understand that you will be assigned a medical home through AHS, based on availability. It is not AHS practice to change medical homes once assigned.
3. Will follow your care plan, for example: get prescribed medications and take as directed.
4. Will promptly supply any information, which may be requested by the program, within the timeframe requested. If any information is found to be intentionally deceitful that would be grounds for disenrollment of the AHS program.
5. Will supply the AHS office with any new medical bills that you receive for services rendered while enrolled in the AHS program.
6. Will allow all information regarding your participation in this program to be shared with other individuals, organizations and agencies solely at the discretion of AHS, in accordance with state and federal laws.
7. Will immediately contact AHS if your income changes or if you become covered by Medicare, Medicaid, private insurance, or any other health insurance/medical benefits.
8. Will apply for Medicaid or other assistance programs if you are eligible.
9. Will authorize the State Department of Human Services to share information regarding your eligibility for Medicaid and other programs with AHS staff and medical providers.
10. Will contact AHS immediately with any changes in your address or phone number.
11. Will take my medications as prescribed by my doctor. I understand that it is my responsibility to have my prescriptions filled and will reapply for my medication supply in a timely fashion. I also agree, if referred, to

apply for free medications through Medication Assistance Programs provided by my Care Navigator or physician.

**You further agree to:**

1. Keep each appointment. (To cancel appointment, notify the provider's office at least 24 hours before your appointment or your appointment will be marked as "No-show." Three (3) "No-show" result in disenrollment from our program.
2. Promptly come to appointments. If arrive more than 15 minutes late to an appointment it will be cancelled and rescheduled. Also will attend appointments personally, no family members or friends will be allowed as representatives for appointments.
3. Call your primary care physician or AHS if you need to be seen anywhere else for treatment. I will contact my primary physician's office or the AHS office for after hour emergency instructions.
4. Present your AHS ID card and a photo ID each time you see a doctor.
5. Limit your emergency room visits to true emergencies. For most problems, such as a sore throat, allergies, etc., you can get faster and less expensive treatment through your primary care physician. AHS clients who repeatedly go to the emergency room without a genuine emergency may be disenrolled from AHS and responsible for emergency room charges.
6. Share the responsibility of maintaining your health by living a healthy lifestyle and cooperating with participating providers.
7. To use any products received from the Gift in Kind closet for the AHS client and family only.
8. Not to return products received from the Gift in Kind closet to stores, sell them in retail stores, garage sales, thrift stores, yard sales, or on the web, or transfer them to another organization or person for any reason including exchange for money, property, or other services.
9. **NOT to request pain medications or other controlled substances from AHS providers.**
10. **NOT to present disability forms to AHS providers, or request tests/procedures designed to prove disability. Treatment by AHS providers is designed to manage and improve your health.**

By signing the patient responsibilities contract the AHS Care Navigator discussed with you, you confirm that you agree to the above conditions and that income information you provided is accurate. If you do not follow the above guidelines, you will be disenrolled from AHS. Your care navigator may have assigned specific responsibilities at the day of your intake. By signing the patient responsibilities agreement you agree to uphold these responsibilities to the best of your ability.

______________________________________ ____________________

Name Date

Social Security Administration

# Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

**TO: Social Security Administration**

| ***My Full Name** | ***My Date of Birth (MM/DD/YYYY)** | ***My Social Security Number** |
|---|---|---|
| | | |

I authorize the Social Security Administration to release information or records about me to:

| ***NAME OF PERSON OR ORGANIZATION:** | ***ADDRESS OF PERSON OR ORGANIZATION:** |
|---|---|
| AccessHealth Spartanburg | 501 Howard St Suite B |

***I want this information released because:** to assist with eligibility for a medical assistance program

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date ____________ to date ____________
5. ☐ My Medicare entitlement from date ____________ to date ____________
6. ☐ Medical records from my claims folder(s) from date____________ to date____________

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

**I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.**

***Signature:** ______________________________ ***Date:** ______________

***Address:** ______________________________

**Relationship (if not the subject of the record):** ______________ ***Daytime Phone:** ______________

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

| 1.Signature of witness | 2.Signature of witness |
|---|---|
| Address(Number and street,City,State, and Zip Code) | Address(Number and street,City,State, and Zip Code) |

# GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0

What is your name? a.__________________________ b. ____ c. ____________________________________
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

| The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.<br><br>After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never. | Past month | 2 to 3 months ago | 4 to 12 months ago | 1+ years ago | Never |
|---|---|---|---|---|---|
| | 4 | 3 | 2 | 1 | 0 |
| **IDScr 1. When was the last time** that you had **significant** problems with… | | | | | |
| a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? | 4 | 3 | 2 | 1 | 0 |
| b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? | 4 | 3 | 2 | 1 | 0 |
| c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? | 4 | 3 | 2 | 1 | 0 |
| d. becoming very distressed and upset when something reminded you of the past? | 4 | 3 | 2 | 1 | 0 |
| e. thinking about ending your life or committing suicide? | 4 | 3 | 2 | 1 | 0 |
| f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts? | 4 | 3 | 2 | 1 | 0 |
| **EDScr 2. When was the last time** that you did the following things **two or more times**? | | | | | |
| a. Lied or conned to get things you wanted or to avoid having to do something | 4 | 3 | 2 | 1 | 0 |
| b. Had a hard time paying attention at school, work, or home. | 4 | 3 | 2 | 1 | 0 |
| c. Had a hard time listening to instructions at school, work, or home. | 4 | 3 | 2 | 1 | 0 |
| d. Had a hard time waiting for your turn. | 4 | 3 | 2 | 1 | 0 |
| e. Were a bully or threatened other people. | 4 | 3 | 2 | 1 | 0 |
| f. Started physical fights with other people | 4 | 3 | 2 | 1 | 0 |
| g. Tried to win back your gambling losses by going back another day. | 4 | 3 | 2 | 1 | 0 |
| **SDScr 3. When was the last time** that… | | | | | |
| a. you used alcohol or other drugs weekly or more often? | 4 | 3 | 2 | 1 | 0 |
| b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)? | 4 | 3 | 2 | 1 | 0 |
| c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? | 4 | 3 | 2 | 1 | 0 |
| d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events? | 4 | 3 | 2 | 1 | 0 |
| e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? | 4 | 3 | 2 | 1 | 0 |

| (Continued)<br><br>After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never. | Past month | 2 to 3 months ago | 4 to 12 months ago | 1+ years ago | Never |
|---|---|---|---|---|---|
| | 4 | 3 | 2 | 1 | 0 |

CVScr 4. **When was the last time** that you…

| | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|
| a. had a disagreement in which you pushed, grabbed, or shoved someone?............. | 4 | 3 | 2 | 1 | 0 |
| b. took something from a store without paying for it? .............................................. | 4 | 3 | 2 | 1 | 0 |
| c. sold, distributed, or helped to make illegal drugs?................................................ | 4 | 3 | 2 | 1 | 0 |
| d. drove a vehicle while under the influence of alcohol or illegal drugs?................. | 4 | 3 | 2 | 1 | 0 |
| e. purposely damaged or destroyed property that did not belong to you?................. | 4 | 3 | 2 | 1 | 0 |

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) .............................................. Yes 1  No 0

v1. ______________________________________________

______________________________________________

6. What is your gender? (If other, please describe below)  1 - Male  2 - Female  99 - Other

v1. ______________________________________________

7. How old are you today?  |__|__| Age

7a. How many minutes did it take you to complete this survey?  |__|__|__| Minutes

**Staff Use Only**

8. Site ID: ____________________ Site name v. ____________________

9. Staff ID: ____________________ Staff name v. ____________________

10. Client ID: ____________________ Comment v. ____________________

11. Mode: 1 - Administered by staff  2 - Administered by other  3 - Self-administered

13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: ____________________

15. Referral comments: v1. ____________________

**Scoring**

| Screener | Items | Past month (4) | Past 90 days (4, 3) | Past year (4, 3, 2) | Ever (4, 3, 2, 1) |
|---|---|---|---|---|---|
| IDScr | 1a – 1f | | | | |
| EDScr | 2a – 2g | | | | |
| SDScr | 3a – 3e | | | | |
| CVScr | 4a – 4e | | | | |
| TDScr | 1a – 4e | | | | |

*GAIN-SS copyright © Chestnut Health Systems. For more information on this instrument, please visit http://www.gaincc.org or contact the GAIN Project Coordination Team at (309) 451-7900 or GAINInfo@chestnut.org*

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think others want you to say.

If the statement does not apply to you, circle N/A.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | When all is said and done, I am the person who is responsible for taking care of my health | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 2. | Taking an active role in my own health care is the most important thing that affects my health | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 3. | I am confident I can help prevent or reduce problems associated with my health | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 4. | I know what each of my prescribed medications do | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 5. | I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 6. | I am confident that I can tell a doctor concerns I have even when he or she does not ask. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 7. | I am confident that I can follow through on medical treatments I may need to do at home | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 8. | I understand my health problems and what causes them. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 9. | I know what treatments are available for my health problems | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 10. | I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 11. | I know how to prevent problems with my health | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 12. | I am confident I can figure out solutions when new problems arise with my health. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 13. | I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |

Insignia Health. "Patient Activation Measure; Copyright © 2003-2010, University of Oregon. All Rights reserved."
Contact Insignia Health at www.insigniahealth.com

121 Greystone Blvd.
Columbia, SC 29210
803-933-9183
www.welvista.org

**Before you mail your application, please check each of the following.**

| | |
|---|---|
| Is this a renewal application? | Yes ❑ No ❑ |
| Is each section completed? | Yes ❑ No ❑ |
| Did you sign and date the application? | Yes ❑ No ❑ |
| Did you attach proof of income? | Yes ❑ No ❑ |
| Did you attach proof of your street address? | Yes ❑ No ❑ |

## PATIENT INFORMATION

| Last Name: | First: | MI: | Social Security Number | Birth Date |
|---|---|---|---|---|
| | | | | |

Patient Address (where you receive your mail) City State Zip

Patient Address (where you live) (attach proof of street address to application) City State Zip

| County in South Carolina | Home#/Cell# | Work or alternate# |
|---|---|---|
| | | |

Ethnic Origin: Asian ❑ Hispanic ❑ Black ❑ White ❑ Other ❑

Gender: Male ❑ Female ❑

Are you a legal resident? Yes ❑ No ❑

List all medications you are allergic to. If no allergies, write "NO."

Doctor/Clinic/Healthcare Provider

Doctor/Clinic/Healthcare Provider's phone#

Circle number of people who live in your household including self:
1 2 3 4 5 6 7 8 9

**Do you have (please check)** ❑ Health Insurance/Affordable Care Act ❑ Medicare ❑ Medicaid ❑ Family Planning /Healthy Check Up ❑ VA Health
**I do not have any medical health insurance** ❑

## PATIENT ELIGIBILITY INFORMATION

**List all household income, gross monthly amounts**

| | |
|---|---|
| Salary/Wages | $ ________ |
| Disability | $ ________ |
| Alimony/Child Support | $ ________ |
| Social Security | $ ________ |
| Pension/Retirement | $ ________ |
| Unemployment/Work Comp | $ ________ |
| **Total Gross Household Monthly Income:** | $ ________ |

**ATTACH PROOF OF HOUSEHOLD INCOME**

Include proof of ALL household income - wages (2 current consecutive paystubs), pension/retirement, social security, SS disability with Notice of Award, child support, alimony, unemployment, worker's compensation, rental income, etc. SEE BACK FOR ADDITIONAL INCOME INFORMATION

## AGREEMENT/ DISCLOSURE / RELEASE

I attest that the above information is complete and accurate. By my signature, I authorize the release of the information about me and my medical condition to Welvista and/or their agents. I authorize Welvista and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the Welvista program, which may include contacting and providing information to social workers, state agencies, healthcare providers or other persons or entities Welvista may deem appropriate to release medical records or required information bearing on my eligibility and benefits under the program. Additionally, I agree that at any time during my enrollment Welvista may request additional documentation to authenticate the statements made on my application. **I will notify Welvista if I become eligible for Medicare, Medicaid, Health Insurance, VA Health Benefits, or if there is a change in my financial status or my mailing address changes.** I have received Welvista's Notice of Privacy Practices Statement.

Patient/Guardian signature ________________________ Date ____________

## WELVISTA USE ONLY

Approved/Denied______ MR #__________________ Keyed______

Plan ID ______________ AC Health ______________

Pt Adv____________________ SCThrive Yes or No

Approval Date____________ Exp Date______________

Facility______________________ FP # __________

## DOCTOR/CLINIC USE ONLY

Doctor/Clinic ______________________

Hospital ______________________

HOP# ____________ HOP ID# ____________

Access Health Group ______________________

# Client Goal Update Questionnaire

This questionnaire is designed to help us better understand your progress on previously set goals and how you have been managing your access to healthcare. Your answers will help us identify how we can improve the services we provide as well as how you are improving.

Name: ________________________________________ Date: ________________________________

Birthdate: ____________________________________ Phone: ________________________________

1) Have you received any assistance from any of the following resources?
   A. DSS (Food Stamps/Child Support)
   B. Food Pantry
   C. Fund Assistance (PCA/Middle Tyger/ Total Ministries/Local churches)
   D. Medicaid Healthy Connection Checkup or Family Planning
   E. Other:________________________________________________________________
   F. No

2) Have you had any doctor's appointments?
   A. Yes, completed all appointments
   B. Yes, missed at least one appointment
   C. No

3) Have you been to the ER within the past 30 - 90 days?
   A. Yes B. No

4) Have you been to Immediate Care within the past 30-90 days?
   A. Yes B. No

5) Have you been admitted to the hospital since your last visit to AccessHealth Spartanburg?
   A. Yes B. No

6) Have you had any changes to any other medical condition?
   A. Yes
   B. No

   If yes, please explain: ______________________________________________________

7) Has the number of cigarettes you smoke per day changed?
   A. Yes, smoking less
   B. Yes, smoking more
   C. No
   D. Question does not apply

8) Do you have all of your medicines?
   A. No, out of one or more medications:____________________________________________________________
   B. Yes
   C. Question does not apply

9) Have you applied for any of the following?
   A. Disability
   B. Medicaid
   C. Medicare
   D. Private Insurance
   E. Affordable Care Act (Obama Care)
   F. Other:____________________________________________________________________________________
   G. None

10) Would you be interested in attending a brief session on any of the following (Please choose all that apply):
   A. Personal Finances
   B. Family Finances
   C. Healthy Eating
   D. Exercise
   E. Employment Assistance
   F. Other (Please specify): ______________________________________________________________________

11) Are you having any problems or concerns that need a follow-up by a staff member?

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