access health SPARTANBURG

To renew with AccessHealth, bring the completed packet & documents (from below) back to the office.

☐ Use **BLACK or BLUE ink ONLY**

☐ **INCOME**-- for **YOU** ***AND*** the following **Adults** that live in your household:

1. your spouse or significant other
2. any dependents you claim on your taxes,
3. Anyone that claims you on his or her taxes.

- **Income from Employment:**
  - Last **2** paystubs for **ALL Working Adults in the Household**
  - If you do not receive paystubs, please ask an AccessHealth staff member what documentation is required
- **Other Income:**
  - Disability Award Letter for ***THIS*** year
  - Social Security or (SSI) Supplemental Security Award Letter for ***THIS*** year
  - Unemployment Statement
  - Retirement Statement
- **NO Income:**
  - No income form—provided by AccessHealth ***OR***
  - Letter from whomever is helping you with your housing, utilities, and food
    - Letter **MUST** have:
      1. Your name
      2. Date
      3. Name & signature of person helping you
      4. Dollar amount person gives you *OR* that they are not charging you

☐ **SNAP**—Current SNAP approval letter

☐ **PROOF OF ADDRESS** (where you are living)

- ANY piece of mail with your name & physical address on it (***Not hand-written)***

After your renewal is approved, a $20 renewal fee can be paid with **cash or money order ONLY**.

Please call our office if you have any questions.

Name: _____ Date of Birth: _____

Physical Address: _____ City: _____ State: ___ Zip Code: _____

Mailing Address: _____ City: _____ State: ___ Zip Code: _____

Social Security or ITIN: _____ Phone Number: _____ (Home/Cell)

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Program Overview

Doctors, hospitals, and other providers have donated their services to help you get well and stay well. The availability of services depends on volunteer providers and could end due to lack of volunteer services/providers. Your responsibilities, the assistance available, and other conditions may change at any time.

We reserve the right to require that you pay for any assistance you may receive based on inaccurate information provided by you. ***You may receive some bills, for which you are responsible, should you need services not currently being donated to the AHS program.***

Clients who anticipate legal action regarding an injury or illness are not eligible for help through AccessHealth.

AccessHealth volunteer providers will not sign-off on any paperwork regarding disability and, therefore, applying for disability must be a separate process.

We are still able to offer clients care needed that is separate from the disability claim or legal action.

You understand and agree that AccessHealth is assisting to coordinate care and locate the appropriate medical and/or social provider(s) for you but is not itself providing any social/medical services. The physicians, practices, governmental or other support organizations which participate with AccessHealth are not employees or agents of us, and we are not responsible for their acts or omissions.

Client Responsibilities

I agree/understand that I:

1. 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 from the AHS program.

2. Will contact AHS immediately with any changes in my address or phone number.

3. Will apply for Medicaid, Medicare, or other assistance programs if I am eligible.

4. Will immediately contact AHS if I become covered by Medicare, Medicaid, private insurance, or any other health insurance/medical benefits.

5. Will be assigned a medical home/doctor through AHS, based on availability. **It is not AHS practice to change medical homes/doctors once assigned.**

6. Referrals to a specialist will be made based on your Primary Care Provider's recommendations.

7. **Limit my Emergency Department visits to true emergencies.** Most problems, such as a sore throat, allergies, etc., can be treated faster by your Primary Care Provider. **AHS clients who repeatedly go to the Emergency Department without a genuine emergency may be disenrolled from AHS and are responsible for Emergency Department charges.**

8. For urgent needs (non-life threatening) ***DURING*** business hours, I will call my Primary Care Provider or AHS if I need to be seen anywhere else for treatment.

9. For urgent needs (non-life threatening) ***AFTER*** business hours, I will contact Regional On-Call and/or seek care at a Spartanburg Regional Immediate Care Center. I will notify AHS of my visit to Immediate Care the next business day.

10. Will follow the guidelines below when accessing services/providers through AccessHealth:

    - Share the responsibility of maintaining my health by living a healthy lifestyle, cooperating with providers, obtaining and taking my medications, following my treatment plan.
    - Be respectful to providers of services connected through AccessHealth.
    - Keep each appointment. If I need to cancel, I will notify the provider's office *at least 24 hours before my appointment* or my appointment will be marked as "No-show." **Three (3) "No-shows" may result in disenrollment from the AHS program.**
    - Be on time for my appointments. If I arrive more than 15 minutes late to an appointment, it will be cancelled and rescheduled.
    - Present my AHS ID card and a photo ID each time I see a provider.
    - I will **NOT** request pain medications or controlled substances from AHS providers.
    - I will **NOT** 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**.

11. Will follow the guidelines below when using Gift in Kind through AccessHealth:

    - Products received from the Gift in Kind closet are for the AHS client and family only.
    - Gift in Kind closet products may not be returned to stores, sold in retail stores, garage sales, thrift stores, yard sales, on the web, or transferred to another organization or person for any reason including exchange for money, property, or other services.

By signing below, I confirm that I agree to the above conditions and that the information I provided is accurate. If I do not follow the above guidelines, I may be disenrolled from AHS.

Signature: _____ Date: _____

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 Street, 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
		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.

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

Chestnut Health Systems

GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center

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. 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) 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…

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

access health SPARTANBURG

Client Update Questionnaire

Name: _____ Date of Birth: _____

Please answer **ALL** the questions to help us understand how you are doing and how we can continue to help you.

Employment, Housing, and Financial

1) Are you currently employed?
   A. Yes B. No

2) Does your employer offer health insurance?
   A. Yes, not eligible B. Yes, too expensive C. No

3) Have you applied for ANY or are you receiving ANY of the following? (Circle **ALL** that apply)

   A. Disability
   B. Medicaid
   C. Medicare
   D. Private Insurance
   E. Affordable Care Act (Obama Care)
   F. Healthy Connections Check-up/Family Planning
   G. Food Stamps/SNAP
   H. Food Pantry
   I. Fund Assistance (PCA/Middle Tyger/Total Ministries/Local Churches)
   J. None

4) Who do you currently live with?

5) In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
   A. Yes B. No

6) In the past 12 months, how many places have you lived? _____

7) In the past 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?
   A. Yes B. No

8) How hard is it for you to pay for the very basics like food, housing, and heating?
   A. Very hard C. Somewhat hard E. Not hard at all
   B. Hard D. Not very hard

(Continue on Back)

Food and Transportation

1) Do you have access to healthy food?
   A. Yes B. No

2) Within the past 12 months, you worried that your food would run out before you got the money to buy more.
   A. Never true B. Sometimes true C. Often true

3) Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   A. Never true B. Sometimes true C. Often true

4) In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
   A. Yes B. No

5) In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
   A. Yes B. No

Mental and Social Health

1) Are you currently being treated for a mental health condition?
   A. Yes
   B. No, don't want help
   C. No, I need help
   D. Question does not apply

2) Do you feel stress---tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time these days?
   A. Not at all
   B. Only a little
   C. To some extent
   D. Rather much
   E. Very Much

3) In the last 2 weeks, how often have you had little interest or pleasure in doing things?
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

4) In the last 2 weeks, how often have you felt down, depressed, or hopeless?
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

5) Are you currently using tobacco/e-cigarettes/vaping? (Circle all that apply) Write **how much** of each one circled.

A. Cigarettes_____
B. Cigars_____
C. Pipe_____
D. Snuff _____
E. Chew_____
F. Nicotine vape_____
G. CBD vape_____
H. THC vape_____
I. Flavoring vape_____
J. Question does not apply

Support

1) In a typical week, how many times do you talk on the phone with family friends, or neighbors?

A. Never
B. One time a week
C. Twice a week
D. Three times a week
E. More than three times a week

2) How often do you get together with friends or relatives?

A. Never
B. One time a week
C. Twice a week
D. Three times a week
E. More than three times a week

3) How often do you attend church or religious services?

A. Never
B. 1 to 4 times per year
C. More than 4 times per year

4) Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups or school groups?

A. Yes
B. No

5) How often do you attend meetings of the clubs or organizations you belong to?

A. Never
B. 1 to 4 times per year
C. More than 4 times per year

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

Welvista
Hope and wellness for the uninsured.

121 Greystone Blvd.
Columbia, SC 29210
803-933-9183
Fax 803-254-0892
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 a copy of your photo ID?	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 _____

Questions? Call 1-803-933-9183 or visit www.welvista.org