Access Health
SPARTANBURG • CHEROKEE • UNION

501 Howard Street, Suite B| Spartanburg, SC 29303|
864-560-0190 phone | 864-560-0199 fax
website: Accesshealthspartanburg.org

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

☐ Use **BLACK or BLUE ink ONLY**

☐ **COPY OF PICTURE ID**

☐ **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

☐ **SNAP**—Current SNAP 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.

Please help US help YOU!!!

Please answer our Satisfaction Survey. There 4 ways to complete one.

- Paper copy--Get one at our office or we can mail it to you
- In office
- Use this link: https://uofsc.co1.qualtrics.com/jfe/form/SV_2lYGEBZZnqjsf2u
- Use the QR code to complete using your phone

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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: _____

SPARTANBURG
Regional Healthcare System

☐ SMC ☐ SHRC ☐ PMC ☐ UMC ☐ CMC
☐ MGC _____

GENERAL CONSENT TO TREAT/PATIENT AUTHORIZATION
ACKNOWLEDGEMENT OF BENEFIT RELEASE

CONSENT FOR MEDICAL TREATMENT
I/we voluntarily consent to medical treatment and diagnostic procedures provided by Spartanburg Regional Health Services District, Inc. (SRHS) and its affiliated hospitals, physicians, clinicians, and other personnel. I/we consent to the testing for infectious diseases, including but not limited to syphilis, AIDS, hepatitis, and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science, and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION
The hospital, practice, and attending physician are authorized to release any medical information required for the application or submission of information for financial coverage, discharge planning and further medical treatment. This includes information for services provided during this visit or for referrals for psychiatric care, sexual assault, or tests for infectious diseases including HIV/AIDS. I/we also agree to the release of medical or other information about me to federal or state government regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS
I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and SRHS. I/we understand that such charges are liquidated damages not subject to dispute, that SRHS expects full payment, and that the acceptance of partial payment does not waive SRHS' right to collect full payment even if there is contrary language accompanying partial payment. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand SRHS can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collection fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

CONSENT TO RECEIVE TELEPHONE AND SMS TEXT MESSAGE COMMUNICATIONS
I/we hereby grant permission and consent to SRHS, our assignees, and third party collections agents: (1) to contact me by telephone at any telephone number I provide; (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law and/or regarding amounts owed by me; (3) to send me short message service (SMS) text messages or emails using any email address I provide; (4) to use pre-recorded/artificial voice message and/or an automatic dialing device (an 'auto dialer') in connection with any communications made to me or related to my account.

PHOTO/VIDEO/TELEVISING
I/we consent to photographs, televising, and/or videotaping for identification, diagnosis, and/or treatment purposes. I/we consent to video monitoring in patient care areas for clinical care and safety reasons.

VALUABLES RELEASE FOR HOSPITAL PATIENTS
I/we were asked to check valuables with the hospital and release SRHS from any liability and assume responsibility for any items not left in the hospital's care. Any valuables not claimed within thirty (30) days of discharge will become the property of the hospital.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
I/we were offered a printed or electronic copy of the SRHS Notice of Privacy Practices (NPP) prior to or at my first visit anywhere within SRHS. I understand that the NPP is posted in all SRHS locations and may also be accessed at www.spartanburgregional.com. The NPP describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the NPP may be changed from time to time.

INDEPENDENT STATUS OF PHYSICIANS
I understand and agree that some of the practitioners furnishing services to me/the patient, such as pathologists may be independent contractors and not employees or agents of SRHS. These independent practitioners who render professional services to me/the patient may bill and collect separately from SRHS. Furthermore, I/we understand that each healthcare provider may be individually contracted with my/our insurance carrier, and the contracts could be different from the SRHS contracts I/we understand that I/we need to find out if each healthcare provider is a member of my/the patient's insurance provider network.

PROVIDER USE OF ARTIFICIAL INTELLIGENCE SCRIBING AND DICTATION
I understand and consent to the use of Artificial Intelligence (AI) scribing and/or dictation during my healthcare appointment. I/we acknowledge that the purpose of AI scribing and dictation is to improve the quality of care I/we receive and to ensure accurate documentation of medical information. I/we understand that the transcribed conversation will become part of my/our medical record and will be treated with the same level of confidentiality as all medical information.

_____
Patient Date of Birth

_____
Patient Name

_____
Date and Time

_____
Signature of Patient/Parent/Guardian/Legally Authorized Representative
(Relationship to Patient)

Patient Label

EPIC DOC TYPE: ASSIGNMENT OF BENEFITS RELEASE
1336 (Rev. 06-24)

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

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				

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?