



2500 Blue Ridge Road, Suite 330, Raleigh, NC 27607
(919) 792-3623 - P
(919) 510-9162 - F

CS Entry
CRx Entry
Mailed
Faxed

PROJECT ACCESS ENROLLMENT APPLICATION

Send Materials in Spanish: YES

RECERT DATE DUE: _____

County Patient Resides: _____

PATIENT 64+ - Has applied for Medicare Yes No – If not, reason: _____

LEGAL Last Name: _____

LEGAL First Name: _____ Nick Name: _____ Middle Name: _____

Maiden Name: _____ **DOB:** _____ (MM/DD/YYYY)

SSN (write **None** if pt has no SSN): _____ - _____ - _____ Gender: Male Female Transgender

Home Phone #: _____ Work #: _____ Cell #: _____

Street Address: _____ **APT #** _____

City: _____ Zip Code: _____

Mailing Address (if different than physical address) _____

Emergency Contact Name: _____ Phone #: _____

HOUSEHOLD VERIFICATION

Marital Status: Married Separated Divorced Single Widowed

Do you have children under the age of 18? Yes No If yes, how many? _____

Do you have children 18-21 in school f/t? Yes No If yes, how many? _____

Are you a student **and** under age 21? Yes No Total # in Household: _____

Your annual gross income: \$ _____

Total annual gross income of **other members** of household: \$ _____

Total Household Income: \$ _____

INSURANCE INFORMATION Insurance Status: No Insurance Insured

Are you currently enrolled in Project Access: Yes No Were you ever enrolled in Project Access? Yes No

Does patient have Medicaid/Medicare/NC Health Choice application pending? Yes No

Is patient currently receiving SS Disability or SSI? Yes No

Is the patient medically disabled? Yes No

REFERRAL INFORMATION

Referring Clinic: _____ Date Faxed: _____

Person Completing Application: _____ Phone: _____

Person Who Booked Appointment: _____

BOOKED WITH: Specialty: _____ Physician: _____

Practice: _____ **LOCATION:** _____

Phone: _____ Fax: _____

Reason for Referral: _____

Appt Date: _____ Appt Time: _____ Referred by: _____

For Additional Appointments, please list on next page

X-Rays, Test Results & Other Medical History must be faxed to the Project Access Provider's office prior to the patients' appointment.

**DO NOT FAX WITHOUT REFERRAL APPOINTMENT AND ALL OTHER INFORMATION COMPLETE
FAX – 919-510-9162**



**PROJECT ACCESS ENROLLMENT
APPLICATION (continuation)**

PATIENT NAME: _____ DOB: _____

2nd Appointment

BOOKED WITH: Specialty: _____ Physician: _____

Practice: _____ **LOCATION:** _____

Phone: _____ Fax: _____

Reason for Referral: _____

Appt Date: _____ Appt Time: _____ Referred by: _____

3rd Appointment

BOOKED WITH: Specialty: _____ Physician: _____

Practice: _____ **LOCATION:** _____

Phone: _____ Fax: _____

Reason for Referral: _____

Appt Date: _____ Appt Time: _____ Referred by: _____

4th Appointment

BOOKED WITH: Specialty: _____ Physician: _____

Practice: _____ **LOCATION:** _____

Phone: _____ Fax: _____

Reason for Referral: _____

Appt Date: _____ Appt Time: _____ Referred by: _____

FAX TO 510-9162



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