



Patient Enrollment Form (Referral Form)

Physicians who are volunteering with the Health Access Project are welcome to refer patients they are treating for HAP services and case management. Patients must meet the following criteria:

- They are Salt Lake County residents;
- Their income is less than or equal to 150% of the Federal Poverty Level (\$15,300 /year for an individual or \$30,975/year for a family of four);
- They are uninsured or under-insured; and
- They are not eligible for public benefits or they require medical services that are not covered by the public benefits they have.

Patient name: _____ DOB: _____

Primary language: _____ Patient phone(s): _____

Patient address: _____

Presenting problem and/or diagnosis: _____

I am providing donated care to this patient and currently they are not in need of any additional services. I would like the patient to count towards my HAP commitment.

I am providing donated care to this patient and they are currently in need of the following:

Referral to a primary care provider: _____

Referral to a specialist: _____

Medication/prescription assistance: _____

Lab work: _____

X-rays: _____

Out-patient hospital procedures: _____

In-patient hospital procedures: _____

Language interpreting for medical appointments: _____

Special Notes: _____

Name of referring volunteer physician: _____ Specialty: _____

Phone number: _____ Fax: _____

Physician signature: _____ Date: _____

Please attach all medical records pertaining to specialty care referral

Please fax this form to the HAP office at 412-3997. Upon receipt of the referral, a HAP Case Manager will contact the patient. Once HAP eligibility has been verified, the Case Manager will call your office to communicate about coordinating the requested care. This form was updated January 24, 2006.