



Patient Enrollment 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:

- Salt Lake County resident
- Family income below 150% of the Federal Poverty Level (for example, \$13,965 /year for an individual or \$28,275/year for a family of four)
- Uninsured or under-insured and not eligible for Medicaid or other public health insurance

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: _____

Referrals for counseling and/or other community support services: _____

Special Notes: _____

Name of referring volunteer physician: _____ Specialty: _____

Private Practice IHC physician University physician Other: _____

Phone number: _____ Fax: _____

Physician signature: _____ Date: _____

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.