



Project Access is a program that offers health care to uninsured adults in Jackson County who do not qualify for public assistance. Project Access is not health insurance. Enrolled patients may see primary care doctors as well as receive other health care services they need at low or no cost.

### **Eligibility**

- U.S. citizen or legal U.S. resident
- Do not qualify for state or federal medical benefits
- Family income must be less than 200% of Federal Poverty Level
- Age 19 or older
- Resident of Jackson County
- Have no medical insurance

### **Step-by-Step Instructions for completing Project Access Application**

1. Complete attached Enrollment Application.
2. Include proof of Jackson County residency. You may provide a copy of any of the following documents to prove residency:
  - Bill or “official” type of mail. Examples include: utility bill, bank statement, paycheck stub, letter from the Department of Human Services or Social Security. Any mail with a P.O. Box address cannot be used.
  - Lease agreement or rent payment receipt
  - Michigan’s Driver’s license or ID Card
3. Include proof of your Household Income.
  - Include proof of income for the past month for all household members.
  - Write down who receives each type of income.
  - Write down how often each type of income is received (weekly, biweekly, monthly, etc.)
  - If you do not have any income, please write how you support yourself.
  - If self employed, verify your estimated business expense and revenue for current year or provide your Schedule C from your most recent taxes
  - If you get income from anywhere listed below, you must include official documentation with your application:

*Over for more instructions and information*

- Social Security Income
- Retired Survivors Disability Insurance
- Educational grants
- Dividends/interest
- Any regular/periodic income
- Most recent income tax return
- Past month's household income
- Gross wages
- Child support
- Spousal support
- Unemployment
- Workers compensation
- Cash assistance
- Rentals
- Royalties
- Pension

4. Return your completed application, proof of residency, and household income to the Community Connections desk (in person) or mail to:

Project Access  
c/o LifeWays  
1200 N. West Ave.  
Jackson, MI 49202

5. We will process all completed applications in the order they are received. After receiving your completed application, we will contact you by mail or phone to let you know the next step in the process.

Please Note: Applications are not complete without copies of verification of Jackson County residency and official documentation/verification of Household Income. You will receive written notification of items missing in order to complete your application. If you DO NOT complete your application within 90 days of notification, your application and submitted materials will be destroyed. If you would like to retrieve these items prior to shredding please contact the Project Access office at 517-796-4511.

6. Information about Project Access is available by calling Central Michigan 2-1-1. Dial 2-1-1 or 866-561-2500.

**Contact Information:**

Kristin Pluta  
Project Access Coordinator  
1200 N. West Ave.  
Jackson, MI 49202  
Email: kristin.pluta@lifewayscmh.org

## Instructions for Completing the Project Access-Jackson County Enrollment Application

1. Enter your full legal name, last name, first name and middle initial.
2. Enter your date of birth.
3. Enter your age.
4. Enter "M" for male and "F" for female.
5. Enter your Social Security Number.
6. Enter your home address, including street number, street name, apartment/lot number, rural route, city, county and zip code. If a different address is used for mailing purposes, include street number, street name, apartment/lot number, rural route, city, county, state and zip code.  
A post office box is not an acceptable address for either Home Address or Mailing Address.
7. Enter the telephone numbers you can be reached, a) home phone b) work phone.
8. Enter your emergency contact a) full legal name, last name, first name b) enter the relationship the person has to you c) enter a phone number the person can be reached.
9. Enter your ethnicity. Information on ethnicity is voluntary and used for statistical purposes only.
10. Enter the highest education level you have achieved.
11. Enter your marital status.
12. Enter the total amount of people in the household including the applicant.
13. Enter your type of housing and how long you have lived there.
14. Answer "yes" or "no" if you are or are not employed.
15. Enter your current status of health insurance.
16. Answer "yes" or "no" and provide any comments if there is a possibility you will receive health insurance from any of the health plans listed in question 15.
17. a. Answer "yes\*" or "no" if you are being treated for any work-related and/or Motor Vehicle Accident related injuries.  
b. Answer "yes\*" or "no" if you are involved in any legal action regarding an illness or injury.  
c. Answer "yes\*" or "no" if you have an illness, injury or disability that will prevent you from working for 12 months or longer.  
\*Affirmative answers to 17a-c make you ineligible for Project Access unless you have a participating Project Access primary care physician who agrees to care for you as an assigned patient under the Project Access program.
18. Answer "yes" or "no" if you currently are pregnant or answer "yes" or "no" if you have been pregnant the last two months.
19. Please provide other comments that need further explaining regarding questions asked on the enrollment application.
20. Enter an email address where you can be contacted for program updates and changes.

Read and check the boxes to indicate you affirm:

- Affirm that the information is true and accurate to the best of my knowledge.
- Authorize the release of this information and any Project Access enrollment documentation to the Community Medication Assistance Program (CMAP) for the purpose of establishing a patient profile and enrolling in the CMAP program and any participating Project Access physician.
- Authorize the exchange of information regarding my eligibility for Medicaid or other MDHS programs with Project Access staff and participating medical providers
- Authorize the exchange of information regarding Jackson Health Plan programs with Project Access staff and participating medical providers
- Authorize the release of information and any Project Access enrollment documentation to any participating Project Access physician.

Sign and date the application.

Note:

- You will receive a phone call or written notification of your application approval or denial from Project Access.
- Applications are not complete without copies of verification of Jackson County residency and official documentation/verification of Household Income. You will receive written notification of items missing in order to complete your application. **If you DO NOT complete your application within 90 days of notification, your application and submitted materials will be destroyed. If you would like to retrieve these items prior to shredding please contact the Project Access office at 517-796-4511.**

Referred By: \_\_\_\_\_

Date \_\_\_\_\_

### Project Access ~ Jackson County Enrollment Application

1. Patient Name	2. DOB	3. Age	4. Sex	5. SSN*
6. Address (city, zip)			7a. Home phone	7b. Work phone
8a. Emergency Contact	8b. Relationship	8c. Phone		
9. Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian Pacific <input type="checkbox"/> Arabic <input type="checkbox"/> Asian other <input type="checkbox"/> White <input type="checkbox"/> European American <input type="checkbox"/> Hispanic, Latino, Spanish <input type="checkbox"/> Native American <input type="checkbox"/> Other				
10. Education Level: <input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate/GED <input type="checkbox"/> Some college <input type="checkbox"/> College Graduate				
11. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed				
12. Number of people in household including applicant:				
13. Housing: <input type="checkbox"/> Own your home <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Other:			How Long:	
14. Are you currently employed? <input type="checkbox"/> yes <input type="checkbox"/> no				
15. Do you currently have health insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Jackson Health Plan <input type="checkbox"/> SSI <input type="checkbox"/> RSDI <input type="checkbox"/> Private Insurance <input type="checkbox"/> Veteran's Medical <input type="checkbox"/> Other				
16. Is there a possibility you will receive health insurance from any of the health insurance plans listed in question 15? <input type="checkbox"/> yes <input type="checkbox"/> no Comments:				
17a. Are you being treated for any work-related and/or Motor Vehicle Accident related injuries? <input type="checkbox"/> yes <input type="checkbox"/> no				
17b. Are you involved in any legal action regarding an illness or injury? <input type="checkbox"/> yes <input type="checkbox"/> no				
17c. Do you have an illness, injury or disability that will prevent you from working for 12 months or longer? <input type="checkbox"/> yes <input type="checkbox"/> no				
18. Medicaid eligibility: Currently pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no Pregnant last 2 months? <input type="checkbox"/> yes <input type="checkbox"/> no				
19. Other comments (include name of current Primary Care Physician if applicable):				
20. Email address (if applicable):				

- I affirm that the information is true and accurate to the best of my knowledge.
- I authorize the release of this information and any Project Access enrollment documentation to the Community Medication Assistance Program for the purpose of establishing a patient profile and enrolling in the CMAP program.
- I authorize the Michigan Department of Human Services (MDHS) to exchange information regarding my eligibility for Medicaid or other MDHS programs with Project Access staff and participating medical providers.
- I authorize Jackson Health Plan to exchange information regarding my eligibility for Jackson Health Plan programs with Project Access staff and participating medical providers
- I authorize the release of this information and any Project Access enrollment documentation to any participating Project Access physician.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Enrolled by: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

\* If not citizen of United States of America-refer to Center for Family Health