PROJECT ACCESS of WAKE COUNTY
Wake County Medical Society Community Health Foundation
4207 Lake Boone Trail, Suite 100
Raleigh, NC 27607
(919) 819-6281 - P
(919) 723-9379 - F

PHYSICIAN ACCEPTANCE FORM

Spanish-speaker ☐
Application was given to patient ☐

Patient Last Name | First Name | Gender | Date of Birth

☐ No SSN

Cell/Home Phone# | Work Phone # | Social Security #

Street Address | City | Zip

Referred by: _____
Print Name (Participating Physician)

_____
Practice Name

_____
Phone | Fax

_____
Person completing this form | Phone/extension

PATIENT was referred to your practice by: _____
Name of doctor | Name of Practice (or Hospital)

If patient is approved for Project Access, indicate the effective date for enrollment (backdated?) _____

Should this patient seek primary care with one of the primary medical clinics that Project Access partners with?
Yes ☐ No ☐ If NO, reason: _____

I understand that the Project Access office will screen the above-referenced patient. Pending eligibility, I hereby accept this individual as a Project Access Participant.

_____
Physician Signature | Date

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PROJECT ACCESS ELIGIBILITY REQUIREMENTS

1. Must be a Wake or Franklin County Resident and provide proper identification.
2. Income below 200% of the Federal poverty guideline.
3. Does not have any health insurance, Medicare or Medicaid.