Project Access Collin County
Compassionate Collaborative Care

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Client Expectations and Responsibilities

We are pleased to have you as a Project Access-Collin County (PACC) client and our goal is to provide you with the necessary care, support and resources to help you succeed on and off our program. As a non-profit organization, PACC is able to continue our mission due to the generosity of our network of Physician Volunteers, Ancillary and Hospital Partners, and Community Clinics. Each of these donate their services, care and expertise to PACC because they want you to succeed as well. In order to be successful, it is imperative that you understand and appreciate the responsibilities and expectations required by you that are laid out below.

Client Expectations

You agree:

- You will schedule appointments with ONLY the doctors to which you have been referred and/or PACC contracted.
- You will keep each doctor's appointment. In extreme circumstances when you must cancel, you will notify your doctor's office at least 24 hours in advance. (Any missed appointments may result in removal from the program.)
- You will arrange for your own translator, when applicable, for you during your appointments.
- You will present your Project Access ID card each time you have an appointment.
- You will follow your physician(s) treatment plan. (i.e. get prescriptions filled and take them as directed)
- You will promptly supply requested eligibility information and documents. Additional documents may be requested while on the program to identify and secure continued assistance.
- You will immediately contact PACC if you become eligible for Medicaid, Medicare, private insurance or other benefits.
- You will apply for other assistance programs at PACC's request.
- You will ONLY use Wal-Mart pharmacy for prescriptions.
- You will use ONLY PACC approved laboratory and diagnostic providers. Failure to comply may result in your financial responsibility for all charges billed.
- You will notify PACC within 14 days of any household changes (Income, address, phone number, living arrangements, etc.).
- You will contact PACC if you are unsure if a service is covered or if you have any questions about your medical care.
- You will keep lines of communication open with any providers, clinics, ancillary providers, and PACC.
- You understand the services you receive are provided to you by a volunteer. Appropriate and professional behavior is expected by you, as well as gratitude.
- You may remain on the program for one (1) year. In special circumstances, your benefits may be extended.
- You may have a co-pay associated with an office visit which is your responsibility.
- You will be removed from the program if you are physically out of Collin County for 45 consecutive days or longer.
- **You will be removed from PACC once you become eligible for any other health benefits, your household income exceeds 200% FPL, or you move out of Collin County.**

You are aware of our services that are <u>not</u> covered or offered:

- Pain Medication
- Pain Management
- Psychiatric Medication
- Over-the-Counter Medication
- Emergency Room Expenses
- Ambulance Services
- Medical Equipment
- Dental Services
- Eye Glasses/Contacts
- Elective Surgery
- Care/Medication for HIV or AIDS

Medications and Prescription Assistance

You understand:

- Many types, but not all medications are provided through this program.
- PACC provides clients up to four (4) generic prescription medications per month and some medically necessary diabetic supplies (not to exceed 30-day supply), up to $1,200 annually.
- When applicable, PACC will submit an application on your behalf for prescription for free or low-cost medication(s). You may be asked to submit additional information, which must be received in a timely manner. Failure to comply may result in your financial responsibility for the prescriptions.
- You must present your PACC ID card each time you have a prescription filled.

This list of responsibilities, available assistance and other conditions may change at any time. By signing this document, you understand and agree to follow all the Client Responsibilities and Expectations listed above.

Signature: _____ Date: _____