Project Access Collin County
Compassionate Collaborative Care
8680 E. Main Street, Suite 4E
Frisco, TX 75033
Phone: (469) 365-0772
Fax: (888) 977-6892
www.PACollinCounty.org

PHYSICIAN VOLUNTEER SIGN-UP SHEET

Physicians registering with Project Access–Collin County (PACC) agree to accept patients into their practices based upon the physician's or physician group's ability to participate.

We ask that each physician accept one new indigent patient per month or as many as they can comfortably absorb into their practice per year. The patient will have their own PACC ID Cards and would be treated the same as any "insured" patient. Please complete one form per physician in the practice.

Physician: _____

Group Name: _____

Specialty: _____ Texas License # _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Physician's **Preferred** Hospital Affiliations:

_____

Physician's E-mail: _____

Number of patients I will treat each month: _____ or total per year _____

Physician Signature: _____

Physician Printed Name: _____

Contact person for PACC communication:

Name: _____Phone: _____

Contact E-mail: _____

Email the completed form to jbolton@pacollin.org or fax to PACC at 888-977-6892. No cover is necessary.

_____Please contact me. I have additional questions regarding my role in PACC

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Project Access–Collin County (PACC) is a community referral program designed to create healthcare access for uninsured residents of Collin County. PACC connects low-income, uninsured residents to Physician Volunteers within the community and provides them with the following services:

- Access to primary care
- Access to specialty care
- Access to diagnostics and ancillary services
- Provides each patient with four generic prescriptions per month plus diabetic medications and supplies and up to $1,200 annually
- Coordination of Prescription Assistance Programs
- Community Heath Navigation Services

Project Access–Collin County is a program of the Collin-Fannin County Medical Society and a partnership with the Collin County Health Care Foundation. The mission of Project Access is to improve the health of our community by creating access to care and services for those most in need.

Project Access–Collin County partners with a network of partners that includes: physician volunteers, other medical providers, laboratories, imaging service providers, health systems, and eight area hospitals.

In order to access services through Project Access–Collin County, patients must be nominated by:

1. The county's indigent healthcare program
2. An area hospital contracted with PACC
3. A participating Physician Volunteer

Patients that are referred to Project Access–Collin County must fit the following guidelines:

- Adult, 18 years of age and older
- Resident of Collin County – must provide proof of residency
- Uninsured (may not have insurance of any kind and must not be eligible for any other type of insurance)
- Income must fall under two times the federal poverty level (Under one times the federal poverty level if coming through the county health department)

Elective Surgery is not included. Only care required for medical purposes can be provided under the PACC program.

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Federal Poverty Guidelines 1/2024

100%		
Family Size	Annual	Monthly
1	$15,060	$1,215
2	$20,440	$1,703
3	$25,820	$2,151
4	$31,200	$2,600
5	$36,580	$3,048
6	$41,960	$3,497
7	$47,340	$3,945
8	$52,720	$4,393
Each Additional Person	$5,380	$448

150%		
Family Size	Annual	Monthly
1	$22,590	$1,883
2	$30,660	$2,555
3	$38,730	$3,228
4	$46,800	$3,900
5	$54,870	$4,573
6	$62,940	$5,245
7	$71,010	$5,918
8	$79,080	$6,590
Each Additional Person	$8,070	$672

200%		
Family Size	Annual	Monthly
1	$30,120	$2,510
2	$40,880	$3,407
3	$51,640	$4,303
4	$62,400	$5,200
5	$73,160	$6,097
6	$83,920	$6,993
7	$94,680	$7,890
8	$105,440	$8,787
Each Additional Person	$10,760	$897

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PACC Referral Request Form

PART A: PHYSICIAN REQUESTING REFERRAL

Physician: _____ Specialty: _____

Address: _____

Contact Person: _____ Email: _____

Office Phone #: _____ Office Fax #: _____

PART B: PATIENT DEMOGRAPHICS

Name: _____ PACC ID #: _____

□ Male □ Female Age: _____ Date of Birth: _____

Address: _____ Apt: _____ City: _____ Zip: _____

Phone #:_____ Work #: _____ Other #: _____

PART C: SPECIALIST REQUIRED

Level of Urgency: □ 0-2 weeks □ 2-4 weeks □ When possible □ As directed _____

Specialist Requested: _____

Please provide most recent H&P, lab report, and relevant diagnostic reports that applies to this visit.

PART D: DIAGNOSTIC PROCEDURE REQUESTED

Level of Urgency: □ 0-2 weeks □ 2-4 weeks □ When possible □ As directed _____

Diagnosis: _____

ICD-10 Code(s): _____

CPT Code(s): _____

Date of Surgery (if applicable): _____ Time of Surgery (if applicable): _____

Facility: _____ Surgeon: _____ Anesthesia: □ yes □ no

Procedure(s): _____

Procedure Length: _____ Special Needs/Requests: _____

PHYSICIAN SIGNATURE _____ Date _____

Please note: PACC patients can be referred to current physician volunteers only. Only medically necessary care will be provided through the PACC program, unless the resource is available. Elective procedures are not covered. For more information, please visit PACollin.org or call 469-365-0772.

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New Patient Enrollment Request Form

Patient Name	Age	Date of Birth	Sex M F
Home Phone #	Work Phone #		Other Phone #
Street Address	Apt #	City	ZIP

Level of Urgency: □ 0-2 weeks □ 2-4 weeks □ When possible □ As directed _____

Physician requesting patient referral:

Print Name (Physician must be a participating PACC volunteer)	Specialty	
Address	City	ZIP
Contact Person	Phone	Fax

Reason for Referral (please PRINT):

_____

_____

Once PACC receives this form and the patient has been screened for eligibility, you will be notified. If you are the patient's PCP, the patient will remain in your medical practice, where you will continue to serve as the patient's medical home.

Please fax this form to PACC at (888) 977-6892. Questions? Call PACC at (469) 365-0772

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_____

Applicant/Client Name (Last, First)

Authorization to Use and Disclose Confidential Health Information

Project Access – Collin County (PACC) is composed of various independent Texas healthcare organizations that provide health care services to individuals living in Collin County regardless of an individual's ability to pay. It may become necessary for PACC partners to use and share confidential health information of participants to better coordinate health care provided to uninsured individuals, to overcome barriers to health care access faced by uninsured individuals, and to implement appropriate disease management systems to improve the health status of uninsured individuals.

This use and disclosure will require an authorization by each uninsured or underinsured individual (or individual's representative) who desire to participate. If you agree to authorize the use and disclosure of your confidential health information among PACC members, as set forth in this form please sign below. By signing below, I authorize employees of PACC, partners of PACC, and health care providers affiliated with PACC partners to use, release and disclose my confidential health care information for the purposes set forth above, to other PACC partners, their employees and health care providers affiliated with PACC.

I understand that "confidential health information" includes diagnoses, diagnostic tests and lab results, and drugs that have be prescribed for me and includes contact information (name, social security number, address, phone number, etc.) and demographic information (gender, race, age, etc.) that is housed in any of the medical records of all the PACC Members.

I understand that information released may include mental health, substance abuse (e.g., drugs, alcohol) and/or HIV/AIDS status, diagnostic and treatment records. IF YOU DO NO WANT THIS INFORMATION DISCLOSED, YOUR OPTION IS NOT TO SIGN THIS AUTHORIZATION. If I sign this Authorization, such information will be received, used and disclosed by PACC Member organizations as authorized by state and federal law.

I understand this is a limited Authorization. I am only authorizing the release of confidential health information that includes diagnoses, diagnostic tests and lab results, drugs that have been prescribed for me; contact information (name, social security number, address, phone number, etc.) and demographic information (gender, race, age, etc.) that is contained in any of the medical records of all PACC Members.

Pursuant to legal agreements with PACC partners, your confidential health information is stored in a centralized health care database operated by PACC. By signing this Authorization, PACC will be allowed to make our confidential health information available through the internet, but only to PACC partners, employees and to health care providers for continuity of care, disease management and health care operations, including quality assessment and improvement and program evaluation.

I fully intend this authorization to cover all PACC partners irrespective of which PACC partner requests that I complete this authorization. Furthermore, I expressly intend that all PACC partners rely on this Authorization, unless and until it is revoked and PACC Members have had a reasonable period of time in which to act on my revocation. I understand that once I sign this authorization it may take approximately two (2) weeks for my medical information to be available to PACC partners and to health care providers affiliated with PACC.

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I understand that I have the right to revoke this Authorization at any time. Revocation must be in writing and sent to:

Project Access - Collin County
8680 E. Main Street
Suite 4E
Frisco, TX 75033

or hand delivered to:

Project Access – Collin County
8680 E. Main Street
Suite 4E
Frisco, TX 75033

I understand that if I submit a revocation, there may be a delay between the time the revocation is received by PACC and the time that my information is removed from further disclosure, but that this delay will generally not exceed seventy-two (72) hours.

I understand that any disclosure of information carries with it the potential for disclosure by the recipient and the information may not be protected by the federal privacy regulations.

I understand that this authorization supersedes and revokes all authorizations signed by me at other PACC member organizations for the same purpose, use and disclosure of confidential health information by PACC Members.

I understand that I may review and receive a copy of the confidential health information released pursuant to this Authorization if I request it. I further understand that I may be required to pay a fee for copies of this information.

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION FORM, AND THAT MY REFUSAL MAY AFFECT MY ENROLLMENT IN PROJECT ACCESS – COLLIN COUNTY AND MY ABILITY TO OBTAIN TREATMENT FROM ANY PACC MEMBER.

I understand this authorization expires two (2) years from the date I sign this Authorization, unless otherwise revoked by me in writing prior to that time.

_____ _____
PACC Applicant/Client Printed Name Date

_____ _____
PACC Applicant/Client Signature Date

I hereby give permission to Project Access – Collin County (PACC) to contact any source to verify statements I have made in my application. I will cooperate fully with PACC personnel to obtain any information necessary to verify statements about my eligibility.

_____ **(Print name of Authorized Representative)** is my representative and I give PACC permission to speak to them in person or on the phone at any time regarding my eligibility or benefits under PACC.

Authorized Representative Information:

PRINT: Last Name, First Name Relationship to Applicant/Client:	Phone Number
Email Address	Signature/Date

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_____

Aplicante/Nombre del Cliente (Apellido,Nombre)

Autorización para Usar y Revelar Información de Salud Confidencial

Project Access–Collin County (PACC) se compone de varias organizaciones de salud en Texas que son idependientes y proveen servicios de cuidado de salud a individuos viviendo en el Condado de Collin sin importar el habilidad del individuo pagar. Puede ser necesario para los asociados de PACC usar y compartir información de salud confidencial de los participantes para coordinar mejor el cuidade de salud proveido a los individuos sin seguro, para supercar las barreras al acceso al cuidado de salud que enfrentan los individuos sin seguro, y para implementar sistemas apropiados de manejar enfermedad y mejorar el estado de salud de los individuos sin seguro.

Este uso y revelación requerá una autorización de cada individuo sin seguro o sin suficiente seguro (o un representante del individuo) quien desea participar. Si Usted está de acuerdo y autoriza el uso y revelación de su informacion de salud confidencial entre los miembros de PACC como especificado en este formulario favor de firmar abajo. Con firmar abajo, Yo autorizo a los empleados de PACC, y a los proveedores de cuidado de salud afilidados con PACC usar, reveler y compartir mi información de salud confidencial para el propósito explicado arriba, a otros afiliados de PACC, sus empleados y porveedores de cuidado de salud afiliados con PACC.

Yo entiendo que "información de salud confidencial" incluye diagnosis, exams diagnosticos y estudios de laboratorio, y medicamentos que me had recetado y su información de contacto (nombre, número de seguro social, dirección, número de teléfono, ect.) e información demográfica (género, raza, edad, ect.) que se encuentra en cualquier expediente medico de los miembros de PACC.

Yo entiendo que la información compartida puede contener historal de diagnosis y tratamiento de salud mental, tratamiento para el abuso de drogas y alcohol o diagnosis de VIH/SIDA. SI USTED NO QUIERE ESTA INFORMACIÓN REVELADO, SU OPCIÓN ES NO FIRMAR ESTA AUTORIZACIÓN. Si yo firmo esta autorización, tal información puede ser recibido, usado y revelado por las organizaciones que son miembros de PACC como es autorizado por la ley del estado y federal.

Yo entiendo que esta es una autorización limitada. Y solo estay autorizando la revelación de información de salud confidencial que incluye diagnosis, examines diagnosticos y estudios de laboratorios, medicamentos que me had recetado; información de contacto (nombre, número de seguro social, dirección, número de teléfono, ect.) y información demográfica (género, raza, edad, ect.) que es contenido en cualquier de los expedients de los miembros de PACC.

De acuerdo con los contratos legales con los afiliados de PACC, su información de salud confidencial se mantiene en un base de datos centralizado para cuidado de salud operado por PACC. Con firmar esta autorización PACC tendrá permiso hacer nuestra información de salud confidencial accessible por medio del internet, pero solamente a los afiliados de PACC, empleados y proveedores de cuidado de salud para continuidad de cuidado, manejo de enfermedades y programas usados para evaluar mejoramiento.

Tengo la intención por completo de autorizar a todos los afiliados de PACC sin distinción de cuál afiliado de PACC require que yo complete esta autorización. Además, yo expresamente tengo la intención de que todos los afiliados de PACC podrán contar con esta autorización a menos que haya sido revocado y los miembros de PACC han tenido un period de tiempo razonable para efectuar mi revocación. Entiendo que al firmar esto pueden pasar aproximadamente dos (2) semanas para tener disponible la

información medica mia para los afiliados de PACC y a los proveedores de cuidado de salud asociados con PACC. Yo entiendo que tendo el derecho de revocar esta autoricación en cualquier momento:

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Revocación tiene que ser sometido por escrito y enviado a:
Project Access–Collin County
8680 E. Main Street
Suite 3E
Frisco, TX. 75033

o entregado a:

Project Access–Collin County
8680 E. Main Street
Suite 3E
Frisco, TX. 75033

Yo entiendo que si someto una revocación, puede haber una tardanza entre el tiempo que se recibe la revocación PACC y el tiempo en que la infomación mia es suya es ineligible para revelación, pero esta tardanza usalmente no pasa las setenta y dos (72) horas.

Yo entiendo que cualquier revelación de información incluye la potencial para la revelación de información por el receptor y que puede ser que la información no sea protegido por las regulaciones federales de privacidad.

Yo entiendo que esta autorización suplana y revoca todas las autorizaciones firmados por mi con otros meiembos u organizaciones de PACC para el mismo propósito., uso y revelación de información confidencial de salud por los miembros de PACC.

Yo endtiendo que puedo revisar y recibir una copia de la información confidencial de salud revelado por conforma esta autorización si se pide. Además entiendo que me pueden requerer pager un cargo adicional para las copials de esta información.

YO ENTIENDO QUE TENGO EL DERECHO NO ACEPTAR FIRMAR ESTA AUTORIZACIÓN, Y QUE NO ACEPTAR FIRMAR PUEDE AFECTAR MI INSCRIPCIÓN EN PROJECT ACCESS–COLLIN COUNTY Y MI HABILIDAD DE RECIBIR TRATAMIENTO DE TODOS LOS MIEMBROS DE PACC.

Yo entiendo que esta autorización expira dos (2) años a partir de la fecha que firmo esta autorización, a menos que de otra manera es revocado por escrito antes que ese tiempo.

_____ _____
PACC Aplicante/Nombre Fecha

_____ _____
PACC Aplicante/Firma Fecha

Por el presente testament doy permiso a – Collin County (PACC) hacer contacto con cualqueira fuente para comprobar cualquiera declaración que he hecho en mi aplicación. Yo cooperaré enteramente con el personal de PACC para obtener cualquiera información necesaria para confirmar declaraciones que se tartan de me elegibilidad.

_____ **(Nombre del Representante Autorizado)** es mi representate y doy a PACC permiso hablar con el/ella en persona o por teléfono cuando sea repecto mi eligibildad o beneficios en PACC.

Información del Representante Autorizado:

Apellido, Nombre Segundo/ Nombre Parentescoal Aplicante:	Número de Teléfono
Dirección de Correo Electrónico	Firma del Aplicante

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Episodic Referral Form

Patient Information

_____

Patient Name | Patient DOB

Referring Provider/Facility

_____

Provider/Facility Name | Contact Person

_____

Phone Number | Fax Number | Email

When/How often would you like us to report back to you:

☐ After initial contact ☐ Bi-weekly ☐ Monthly ☐ Other_____

Best method in reporting to you: ☐ E-mail ☐ Fax ☐ Mail ☐ Phone

Over the next 90 days, what are your expectations for this patient:

☐ Medication assistance

☐ Transportation assistance

☐ Health information

☐ Interpretation/Translation Services

☐ Receipt of appointment reminders

☐ Assistance with other community and/or government resources

☐ Adherence coaching

☐ Other (please explain) _____

_____

Please explain the situation(s) that prompted this request:

_____

_____

_____

Please fax this form to the PACC office at (888) 977-6892. For questions, call (469) 365-0772.