accesshealth™
www.myaccesshealth.org

BRAZOS RIVER FLOOD RECOVERY 2016

Patient Information

Please complete all portions of this form to register for services at AccessHealth. AccessHealth receives grant funds to provide services, and is required to report population based demographic information about our patients. Individuals' names and information are **NOT** reported.

Social Security Number: _____-_____-_____ ***Prefix:*** _____Miss_____MR. _____MRS._____MS.

First Name:_____ **Middle Initial:**_____**Last Name:** _____

Nickname:_____ **Suffix:**_____Jr._____Sr._____II ____III_____IV

Date of Birth (MM/DD/YY) : _____/_____/_____ **Sex (Gender):**_____*Female* _____*Male*

Street Address:_____ **City:**_____ **Zip:**_____

Email:_____ **Cell Phone:** (_____)_____- _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____- _____

Are you Hispanic/Latino? __ Yes _____ No **Are you a U.S. Military Veteran?** _____ Yes _____ No

Race: _____ American Indian/Alaskan Native ____ Asian _____ Native Hawaiian
_____ Black/ African American ____ White _____ Pacific Islander _____ Unknown

My needs from Access:

- Medication Prescription & Refill _____
- Outpatient Medical Appointment _____
- Counseling _____
- WIC _____
- Tetanus vaccine _____ _____

June 2016

NCQA FQHC United Way
United Way of Greater Houston

Self-Declaration Form for Disaster Victims

For all Brazos River Flood Recovery 2016 participants.

_____ is a victim of a disaster and is requesting assistance from AccessHealth.
Participant name(s)

Mark the statements that describe your situation:

_____ I/we have provided acceptable proof of identification.
_____ I/we did not provide acceptable proof of identification.
_____ My household is currently residing in Texas and I have provided proof of residency.
_____ My household is currently residing in Texas and did not provide acceptable proof of residency.

Certifications: Below is valid for **30** days only. A reassessment shall be done on _____.
date

Identification:

_____ is an applicant to AccessHealth and a victim of a disaster and has no acceptable proof of identification for myself/my child.

_____
Applicant/Parent/Caregiver Date

Residency:

_____ is an applicant to AccessHealth and a victim of disaster and am residing in Texas with no acceptable proof of residency for myself/my child. I/we are residing at _____.

_____
Applicant/Parent/Caregiver Date

Proof of Income for Homelessness:

This is to certify that _____ is homeless and unable to provide proof of income due to being a victim a disaster. The applicant or
(Applicant's name)
the parent/guardian/caregiver who is applying on behalf of a child is self-declaring they have no proof of income.

_____
Applicant/Parent/Caregiver Date

June 2016

United Way of Greater Houston