DOCTORS CARE
Accessible Care for the Underserved

Program Application | *We serve Arapahoe, Douglas and Elbert counties, excluding the city of Aurora.*

Please ensure all items are filled in completely and all documents are gathered before scheduling your intake interview. Failure to do so will delay your medical care. Please call to schedule your intake appointment as mailing your application will also delay the enrollment process.

All information will be kept confidential.

REQUIRED MATERIALS (For all financial contributors to the household) Date: / /

Please use this checklist to ensure you have all necessary items.	Included	Does Not Apply
1. LAST THREE MONTHS of pay stubs (or all pay stubs if you have been working less than three months)	☐	☐
2. LAST THREE MONTHS of Profit and Loss records if self-employed	☐	☐
3. LAST THREE MONTHS of detailed checking and savings account statements for all adult family members	☐	☐
4. Any medical bills from the LAST THREE MONTHS *(for intake only)*	☐	☐
5. LAST THREE MONTHS of any medical payments made, NOT including Doctors Care co-pays (i.e. copies of money orders, cancelled checks, or statements showing payments)	☐	☐
6. LAST THREE MONTHS of daycare (while parent works) or child support payments	☐	☐
7. Last year's tax return or all W-2 forms	☐	☐
8. Proof of the amount awarded for: unemployment, food stamps, subsidized housing, social security, social services, child support, education grants or any other income	☐	☐
9. Statements for all stocks, bonds, land, cash value of life insurance, CDs, IRAs, 401Ks, etc.	☐	☐
10. Proof of current rent or mortgage statement (i.e. copy of lease, copy of rent receipt)	☐	☐
11. Letter from friend or family member you live with describing the **dollar amount** in rent, if any, you pay to them	☐	☐
12. Proof of address (i.e. copy of lease, utility or phone bill in your name)	☐	☐
13. Letter from friend or family member designating the **dollar amount** of any financial support he or she gives you	☐	☐
14. Proof of higher education tuition payments or student loan payments	☐	☐
15. Copy of photo ID	☐	☐

Applicant Information Have you or any member of your family ever applied for Doctors Care in the past? Yes ☐ No ☐

Last Name _____ First _____ M.I. _____ Gender _____

Social Security No. _____ Date of Birth _____ Relationship/Marital Status _____

Employment Status _____ County _____

Street Address _____ Apartment/Unit # _____

City _____ ZIP _____ Email Address _____

Home Phone _____ (Voicemail OK? Yes/No) Cell Phone _____ (Voicemail OK? Yes/No)

Work Phone _____ (Voicemail OK? Yes/No) Preferred method of contact _____

Applicant's Family Members (Please include all family members in the home regardless of whether they are applying for Doctors Care.)

Name	DOB	Relationship	SSN	Currently has Medicaid, CHP+ or Other Insurance?	Needs Doctors Care?
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐

Monthly Household Income

Type of Income	Monthly Amount
Job 1 (Gross Pay)	
Job 2 (Gross Pay)	
Alimony	
Child Support	
SSI/SSDI/Social Security	
Pension/Retirement	
Unemployment	
Food Stamps	
Grants/Scholarships/Loans	
Subsidized Housing	
Gifts/Personal Loans	
Other Income	
Total Income	

Monthly Household Expenses

Type of Expense	Monthly Amount
Rent/Mortgage	
Child care	
Higher Education	
Child Support	
Medical Payments	
Other:	
Total Expenses	

Other Assets

Type of Asset	Current Value
Bank Account(s)	
IRA/401 K	
Stocks/Bonds	
Life Insurance Cash Value	
Inheritance	

Type of Asset	Current Value	Balance Owed
Car(s)		
Home(s)		

Please describe your employment or unemployment situation. _____

When did you start? (___/___/___) Is this: seasonal ☐ year round ☐?

Is your income LESS than your expenses? Yes ☐ No ☐ If yes, please explain what steps you are taking to resolve this situation.

Is your income MORE than your expenses? Yes ☐ No ☐ If yes, please explain how you are managing your excess income.

Please describe the medical reason(s) for which you are applying to Doctors Care. _____

PLEASE COPY AND FILL OUT BOTH SIDES FOR EACH ADULT APPLYING FOR THE PROGRAM.

Personal Health History (All questions contained in this questionnaire are strictly confidential. Please attach additional sheets if necessary.)

Name: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Race: ☐Caucasian ☐Black/African American ☐Asian ☐Amer. Indian/Alaskan Native ☐Pacific Islander ☐Other ☐Choose Not to Answer

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Choose Not to Answer

Sexual Orientation: ☐Heterosexual/Straight ☐Gay/Lesbian ☐Bisexual ☐Other ☐Not sure ☐Choose Not to Answer

This line to be filled out by eligibility counselor: BMI: _____ ☐Underweight ☐Normal weight ☐Overweight ☐Obese ☐Severely Obese

Do you have any potential settlements? (ex: insurance claim, car wreck, worker's compensation, etc.) ☐ Yes ☐ No ☐ Unsure

List Any Current Health Concerns

Surgeries & Other Hospitalizations Including ER Visits (within the last THREE MONTHS)

Date	Reason	Hospital

List Your Medications

Medication Name	Strength	How often taken

Symptom Check

Check if you have ever had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Circulation	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Gynecology	
☐ Chest/Heart	☐ Prostate	

Potentially Addictive Substances

(Please answer honestly. All answers will be kept confidential.)

Alcohol

AUDIT ☐

Do you currently drink alcohol? ☐ Yes ☐ No How many drinks per week? _____

Tobacco

QUIT MATERIALS ☐

Do you currently use tobacco? ☐ Yes ☐ No

Drugs

DAST ☐

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Pain Management Prescriptions

SOAPP ☐

Are you currently taking any **prescription pain** medication? ☐ Yes—please continue ☐ No—Please stop here and sign the bottom of this form.

Please list all pain medications and dosage you are currently taking.	**How long have you been on this medication?**

Please list all providers who have prescribed pain medications for you.	**List dates you have seen these providers.**

What is the medical condition that requires you to take pain medication?

Do you feel you will be in need of long-term pain medication management? ☐ Yes ☐ No

When do you anticipate being able to stop taking the pain medications, if ever?

What other forms of therapy (if any) have you tried to control your pain (acupuncture, chiropractic, physical therapy, hot or cold packs, etc.)?

If you need help with chronic pain management, would you be willing to try these alternative therapies? ☐ Yes ☐ No

Doctors Care providers do not treat chronic pain through the use of medication. Please understand that asking any Doctors Care provider for narcotic medication to treat chronic pain may result in immediate termination from the program.

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to enrollment in the program, I understand that false or misleading information in my application or interview may result in my immediate termination.

Signature _____ Date _____