

Center for Health and Human Rights (CHHR)

Healthcare Access & Services Intake Form | Web: healthasright.org

1. Applicant Information & Demographics

Full Legal Name: _____ Date of Birth: _____
Phone Number: _____ Email Address: _____
Household Size: Total Adults: _____ Children: _____ Preferred Language: _____

2. Insurance Status & Financial Screening

■■ REQUIRED VERIFICATION: Please provide the 2 most recent paystubs for every working individual in the household along with this application.

Annual Household Income: \$ _____ / year

Current Insurance Status:

- ☐ Uninsured (No Coverage)
☐ Medicaid / FAMIS
☐ Medicare
☐ Private Insurance / Employer Plan

Healthcare Financial Obstacles:

- ☐ Currently experiencing heavy medical debt
☐ Cannot afford required prescription copays
☐ Lost healthcare coverage in past 60 days

3. Requested Healthcare Services & Access Mapping

- ☐ Primary Care / Community Clinic Referrals
☐ Dental Care Access & Urgent Procedures
☐ Mental Health Counseling / Therapy Placement
☐ Prescription Medication Financial Support / Copays
☐ Vision Exams & Low-Cost Eyeglasses Assistance
☐ Affordable Marketplace Insurance Navigation

4. Medical History & Urgency Screening

Diagnosed Chronic Conditions (Check all that apply):

- ☐ Diabetes ☐ Hypertension / High BP ☐ Asthma / COPD
☐ Active Cancer Treatment ☐ Cardiovascular Issues ☐ Currently Pregnant

Last Medical Evaluation: ☐ Within 6 Months ☐ 6–12 Months ago ☐ Over 1 Year ago ☐ Unsure

5. Privacy Notification, Release & Authorization

The Center for Health and Human Rights (CHHR) coordinates care following strict privacy guidelines. I authorize CHHR staff to share my validated application data with partner medical, dental, and pharmaceutical providers solely to coordinate appointments, enrollment assistance, and authorized emergency medical voucher payouts.

Applicant Signature: _____ Date: _____

6. INTERNAL STAFF / CASEWORKER REVIEW ONLY

☐ Application Complete ☐ 2 Most Recent Paystubs Received & Verified ☐ Approved Referral ☐ Denied
Assigned Partner Clinic Site: _____ Rx Voucher Limit: \$ _____
Caseworker Signature: _____ Date: _____