Project Access New Haven
"Our community cares"

Letter of Interest

I, _____, M.D./D.O., agree in principle to participate in the New Haven Project Access Physician Volunteer Network. The amount of volunteer services I may be willing to contribute is indicated below.

1. I understand that I will voluntarily provide services without compensation to patients seen through the Project Access Program. I will designate the amount of free services. The Project Access Staff will refer patients to participating physicians on a rotating basis.
2. As a specialist, I understand that patients will be referred through Project Access for consultation services for appropriate specialty care. It is my obligation to diagnose and treat this condition if it is deemed appropriate through my assessment of the patient. I agree to follow the patient at no charge for up to six months (if needed) so long as the patient continues to meet the Project Access enrollment criteria and is compliant with the physician's plan of care. At the end of six months, patients are re-evaluated by Project Access for financial need.
3. As a primary care physician, I understand that it is my obligation to address primary care issues including preventive care as deemed appropriate through my assessment of the patient. I agree to follow the patient at no charge for a period up to six months or as long as the patient continues to meet the Project Access enrollment criteria and is compliant with the physician's plan of care. At the end of six months, patients will be re-evaluated for continued financial need.
4. I agree only to donate services as a physician; I will not be responsible for any other ancillary health services costs such as hospital, anesthesiology, lab or radiology. I understand that Project Access will assist patients, as needed, to arrange additional volunteer or low-cost ancillary health care services if possible.
5. As the New Haven Project Access Program develops, I understand that I will be offered a Letter of Agreement to formalize my participation. This will automatically renew. However, I have will have the option of changing the level of participation at any time by completing a new Letter of Agreement.
6. I understand that I may terminate that Letter of Agreement for any reason by giving 30 days written notice. I understand that Project Access may terminate that Letter of Agreement for any reason by giving 30 days written notice.
7. I understand that Project Access will maintain a confidential program evaluation/research database. Given that all Project Access patients will sign Release of Information Consent Forms, I agree in principle to participate in data collection through the submission of claims data and appropriate transfer of health record information and to participate in data collection by completing reasonable Project Access forms and surveys.
8. I understand Project Access will document its findings and recognize the services volunteered by participating physicians.
9. All physicians participating in Project Access will agree to provide services without discrimination based on race, religion, age, sex, national origin or ancestry, economic status, handicapped or disabled condition, sexual orientation or political affiliation or belief.

Name: _____

Specialty: _____ Practice Manager: _____

Phone: _____ FAX: _____ Pager: _____

E-mail: _____

I agree in principle to participate in the New Haven Project Access Program.

Amount of Volunteer Services:

_____ # of patients per month **OR** _____ # of patients per year

_____ _____

Physician Signature Date

Please mail or fax your Letter of Interest to:

Project Access New Haven • P.O. Box 9293 • New Haven, CT 06533 • Fax: 203-773-9711