



**PARK
PLACE
MEDICAL
CENTER**

**Healthcare
For The
Homeless**

**3415 GRANBY STREET
NORFOLK, VIRGINIA 23504**



PARK PLACE MEDICAL CENTER

-Neighbors helping Neighbors-

3415 Granby Street Norfolk, Virginia 23504

(757) 533-9108

MISSION STATEMENT

Portsmouth Community Health Center, Inc.

(Park Place Medical Center)

Is a not for profit, community based primary medical care organization dedicated to providing quality health care while maintaining patient safety to the residents of Portsmouth, Norfolk and surrounding areas without regard to their ability to pay.

Our goal is to keep families healthy through expert care and healthy lifestyle education

Park Place Medical Center opened the doors for patient care in January 2002. Park Place Medical Center is a non-profit community health center which offers primary care to uninsured as well as the insured. Park Place Medical Center is operated by the Portsmouth Community Health Center, a non-profit organization dedicated to providing good quality health care to the community.

SERVICES WE OFFER:

- Adult Health Care*
- Pediatric Health Care (Immunizations and Vaccinations)*
- Diagnosis and Treatment of minor and chronic illnesses*
- Laboratory Services*
- Health Education*
- Flu and pneumonia vaccines*
- Medication Assistance*
- Referral program to specialty care providers*
- Health Disparities Collaborative with a focus on diabetes*
- Patient Care and Case Management for the Homeless Program*

ALL OUR PHYSICIANS ARE BOARD CERTIFIED:

- Dr. Subir Vij, (Medical Director) Internal Medicine and Geriatrics*
- Dr. Saundra Winstead, Family Physician*
- Dr. Anoj Goel, Internal Medicine, Endocrinologist*
- R.C. Kapoor, Internal Medicine*

OUR CURRENT STAFF

- 8 full time employees*
- 1 part time employee*

HOURS OF CARE:

Monday, Wednesday, Friday 8am to 5pm
Extended Hours: *Tuesday and Thursday 8am to 8pm*
First and Third Saturday 8am to 12 noon

Park Place Medical Center

Health Care for the Homeless

NEW PATIENT ENROLLMENT PROCESS

1. The person is deemed homeless by a referring agency
2. The referring agency's case worker completes the PPMC referral form and faxes it to (757) 622-6381.
(PPMC fax number)
3. The referring agency calls PPMC at (757) 533-9108 to schedule an appointment for the new patient.
4. The referring agency should help the new patient complete the PPMC's patient registration packet.
5. The patient should come to PPMC with the following documents ready to give to the front desk patient registration person:
 - The intake form that was completed by the agency.
 - The completed PPMC patient registration application packet.
 - A picture ID (Federal Requirement for Community Health Centers)

Once a patient has been registered at Park Place, they will be given a special Park Place HCH Health Plan card. Patient should bring this card back with them for future visits and this will cut down on their registration time.

**PARK PLACE MEDICAL CENTER
HCH - HEALTH PLAN
I. D. CARD**



Insurer: _____

Insurance: _____

Call for Appointment: 533-9108
Portsmouth Community Health Center, Inc.
WARNING: This is not an insurance card!
Present this card during every visit

PLEASE NOTE: The person must be deemed homeless through an agency in order not to be classified as a sliding fee patient.

Any questions about the above instructions please contact

Yvonne Price, LPN Case Manager/Outreach Worker by phone at (757) 232-1196 or email yprice@portshealth.org

See Attachments

Instructions prepared: October 8, 2007

**Park Place Medical Center
3415 Granby Street
Norfolk, Virginia 23504
Telephone # (757) 533-9108
Fax (757)622-6381**

HCH REFERRAL

CLIENT NAME _____

REFERRED BY _____

CONTACT PERSON _____

AGENCY PHONE # _____

DATE REFERRED _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____

APPOINTMENT DATE AND TIME _____

Notes/Additional Information -

Patient Resides? Please Check one below...
 Shelter Street Transitional Other: _____

PORTSMOUTH COMMUNITY HEALTH CENTER, INC.
(PARK PLACE MEDICAL CENTER)

Date _____

HCH # _____
 New

HEALTH CARE FOR THE HOMELESS
BASELINE INFORMATION

So that we can help you get care, please answer these questions Hampton Roads

Last Name _____ First Name _____ MI _____ Jr. Sr. III _____

Alias (AKA) _____ Date of birth _____ Social Security # _____ (Circle)

Sex (Check one) Male Female

Race (Check one) White Black Hispanic Asian American Indian Pacific Islander Other

Education (Check off on the ONE that best describes the highest level completed)

None Grade school Some high school High school grad / GED
 Vocational /Tech School Some college College grad.

Father's full name (First Name, MI, Last Name) _____

Mother's maiden name (First Name, MI, Last Name) _____

Where were you born? City _____ State (If U.S.) _____
Country (If outside U.S.) _____

What is your marital status? (Check one) Single Married Separated/Divorced/Widowed Unknown

How many children do you have? _____ How many under 18 years old? _____ How many stay with you? _____

DO you have any relatives or friends in Hampton Roads Yes No Unknown

Are you currently living ... (Check one) By yourself With a partner With family #of family members _____

Where did you spend last night? (Check one) Shelter Street Hospital Jail/Prison Friend
 Relatives Detox Other Unknown

Current address _____ None
Address City State Zip

Phone number _____

Mailing address _____ None
Address City State Zip Same as above

How long have you been in Hampton Roads Less than 1 month 1-5 months 6-12 months
 1-5 years More than 5 years Unknown

Do you have a regular place to stay? (Not a mission or a shelter) (Check one)

CI Yes

No When was the last time you had a regular place to stay?

- Less than 1 week
- 1-4 weeks
- 1-5 months
- 6-12 months
- 1-3 years

What is your main reason for not having a regular place to stay? (Check up to three)

- Transient or traveling out of town
- My lifestyle
- Physical abuse
- Family conflict
- Released from psychiatric hospital
- Released from jail or prison
- Financial problems
- Other
- Eviction or foreclosure
- Drug / alcohol abuse
- Unemployed

Have you ever been employed? (Check one)

Yes What is your usual occupation? _____ No

Are you currently employed? (Check one)

CI Yes What kind of work are you doing? _____ No

What is your monthly income? _____ None

Are you a veteran of the military? (Check one) Yes No

Have you ever applied for public housing? (Check one)

Yes Where? _____ Date _____ No

Where do you usually receive your health care? (Check one)

- Emergency room
- Clinic or hospital
- Private doctor
- Prison
- Haven't received care in ____ years

Who can we contact in case of emergency? _____

First Name Last Name

Address

Phone Number

This person listed above is (Check one) Mother Father Sister Brother Spouse
 Other relative Friend Other

Are you receiving anyone of the following benefits? (Check one response for each)

	Yes	No	Pending	
Medical Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number _____
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number _____
State Public Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SSI / SSDI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Veterans Retirement/Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Workers Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Thank you for taking the time to provide HCH with this information
It allows us to serve you better

Interviewed by _____

**INTAKE APPLICATION
HCH**

Norfolk (757) 533-9108 • Portsmouth (757) 393-6363

PERSONAL DATA

1. Name _____ Sex _____ Racial/Ethnic Background _____
2. Address _____ Telephone _____
3. Date of Birth _____ Age _____ SS# _____ Veteran _____ Yes _____ No _____
4. Marital Status (S) _____ (M) _____ (SEP) _____ (W) _____ (D) _____
5. U.S. Citizen _____ Yes _____ No _____ Other: Explain _____
6. List number of family members living with you _____ Responsible Party _____

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7. Do you receive (Check and fill in amount): TANF _____ Food Stamps _____ GR _____
SSI _____ SSA _____ VA Pension _____ Other Pension _____ WIC _____
Medicaid _____ Medicare _____ Other Health Insurance _____
 8. Reason for homelessness? _____
 9. Currently Employed _____ Income _____ (weekly) _____ (monthly) _____
 10. What is your usual occupation? _____
 11. List all drug allergies _____
 12. Indicate medications you currently take _____
 13. Do you consume alcohol [] drugs [] When did you last use? _____
 14. Are you receiving services from another doctor [] hospital [] Health Dept. []? _____ Yes _____ No _____
 15. Describe any medical problems(s) you need assistance with _____
 16. Are you receiving services from: Churches [] Community Services Board [] PCHC, Inc. []
Social Services [] Other [] ?

Have you had the following:

	Yes	No	Decline	
TB Skin Test	[]	[]	[]	If yes, date of last TB Skin Test _____
HIV Test	[]	[]	[]	If yes, date of last HIV Test _____
Physical	[]	[]	[]	If yes, date of last Physical _____
Immunizations	[]	[]	[]	If yes, date of last Immunization _____
				If you do not wish to have test completed check decline, otherwise check no

**I authorize the release of any medical information necessary to process this application.
I consent to examination, ancillary and/or tertiary services as designated herein.**

AGENCY USE ONLY

Signature _____ Date _____
Case Manager _____ Notes _____
Status _____