HealthyCare Card Application

This is an application for the HealthyCare Card, a program of Healthy Community Network.

The HealthyCare Card (HCC) is a program which provides discounts to care for those who require financial assistance with their medical care.

Healthy Community Network requires all persons to have health insurance whenever possible.

The HealthyCare Card is not insurance or considered a "Qualified Health Plan" or "Credible Coverage."

Why are you applying? ☐ Medication assistance ☐ Ongoing health issues ☐ Outstanding medical bills ☐ Copay assistance ☐ Deductible: Amount $____ ☐ Other

Who referred you to Healthy Community Network? _____

Do you have a health insurance plan? ___ Yes ___ No

No, why and submit documentation of why you don't have the following

- An employer's health insurance plan _____
- The Federal Health Insurance Marketplace www.healthcare.gov _____
- HealthChoices PA (Medical Assistance) www.compass.state.pa.gov_____
- Other insurance _____

If you are not eligible for health insurance through the Federal Health Insurance Marketplace because of citizenship or residency status, you may be eligible for the HealthyCare Card.

Yes, I have health insurance.

- If you have Medicare or another form of health insurance you may be eligible for assistance with high out-of-pocket costs.
- If you have Medicare or primary insurance you can apply.

If you are eligible for health insurance, you will need to pursue these options before submitting this application. If you have questions you can call us and we can help guide you.

Send completed application with copies of all required documentation and check for the right amount of postage before mailing envelope to:

In York and Lebanon County:

Healthy Community Network
116 S. George Street, Suite 101
York, PA 17401

In Adams County:

Healthy Community Network
39 N. Fifth Street
Gettysburg, PA 17325

HEALTHY COMMUNITY NETWORK

All information provided in this application will remain confidential

12/2016

Questions??
Call Healthy Community Network
York County: 717-812-2990
Adams County: 717-339-2439

☐ First time applying

☐ I am renewing

HealthyCare Card Application Instructions

Please be sure to complete the entire application & include copies of the following:
(Check off the copies included with this application)

☐ **Federal 1040 Tax Return for most recent year (Required)**

- For self-employment & investment income you must include Schedule C, D & E when applicable.

I did not file taxes last year.

Signature *Date*

☐ Pay stubs:
___ Weekly: 4 pay stubs
___ Bi-weekly: 3 pay stubs
___ Monthly: 3 pay stubs

☐ Public Assistance, SNAP Eligibility Letter

☐ Unemployment Benefit Letter

☐ Workers Compensation/Disability

☐ Child Support Income, Spousal Support

☐ Social Security & Pension Statements for current year

If you have no income for the last 30 days, please call 1-800-429-2430

☐ Provide a copy of Photo ID

☐ Copy of all medical insurance cards

☐ Bank Statement(s) & Household Assets (include all pages)

___ Copies of 3 months of full bank statements for all accounts held

___ Self-employed: Copies of 6 months of all personal & business accounts

☐ Copies of household bills if you have Medicare or will be Medicare eligible within one year (*see Section 4 on Page 4)*

► *If marital status is separated, you must provide legal documentation of separation or include copies of spouse's income.*

****

IMPORTANT: **Incomplete applications will be returned to you unprocessed. Please call us with questions.**

All information provided in this application will remain confidential

1. HOUSEHOLD INFORMATON: How many people live in your house:_____

How many dependents claimed on tax return: ____

Last Name:	Telephone Number: Home:_____Cell:_____

Mailing Address:	City:	State:	Zip Code:

2. ALL HOUSEHOLD GROSS INCOME: ***Write in dollar amounts and attach copies of income.***
Do NOT leave blank

Source	Wages	Gross amount Per pay	How often is this income received	Who receives the income
Employer Name:	□ Full time □ Part time □ Seasonal	$	□ Weekly □ Every Two Weeks □ Monthly □ Twice Per Month □ Annually	
Employer Name:	□ Full time □ Part time □ Seasonal	$	□ Weekly □ Every Two Weeks □ Monthly □ Twice Per Month □ Annually	
Employer Name:	□ Full time □ Part time □ Seasonal	$	□ Weekly □ Every Two Weeks □ Monthly □ Twice Per Month □ Annually	
Unemployment		$	Include a copy of Benefit Letter	
Child Support/Alimony		$	Include a copy of Benefit Letter	
Workman's Comp		$	Include a copy of Benefit Letter	
Disability/Social Security		$	Include a copy of Benefit Letter	
Pension		$	Include a copy of Benefit Letter	
Investment/Rental Property Income		$	Include a copy of Benefit Letter	
Public Assistance (Cash and food stamps)		$	Include a copy of Benefit Letter	
Other		$	Include a copy of Benefit Letter	
TOTAL:		$		

3. HOUSEHOLD ASSET INFORMATION: **Include <u>all</u> pages of most recent statements for the last 3 months, if self-employed the last 6 months**

Asset: **Copies needed on each account held**		**Current Balance:** **Do NOT leave blank**		**Who owns the asset**
Checking Account Balance		$	□ No Account	
Savings Account Balance		$	□ No Account	
Other (Ex: Christmas Club, Vacation Club)		$	□ No Account	
401(K) and 403 (b)		$	□ No Account	
IRA or other retirement plans		$	□ No Account	
Money Market		$	□ No Account	
Certificate of Deposit (CD)		$	□ No Account	
Other Investments (Ex: stocks, bonds, trust funds)		$	□ No Account	

All information provided in this application will remain confidential

4. HOUSEHOLD EXPENSE INFORMATION:		
Copies of monthly bills are required if you have Medicare or You are going to be eligible in the next 12 months		
Expense:	**Monthly Payment:**	**Balance of Account:**
Rent/Mortgage	$	
Lot Rent	$	
Utilities:		
Gas	$	
Electric	$	
Oil	$	
Phone/Cell (one only)	$	
Water	$	
Sewer/Garbage	$	
Insurance:		
Life	$	
Health	$	
Auto	$	
Home	$	
Taxes:	$	
Property	$	
School	$	
Loan	$	
Dr./Medical Bills	$	
Medications	$	
Transportation: Gas/Oil	$	
Other:	$	
TOTAL	$	

5. Person Applying #1

Last Name:	First Name:	Middle:	Date of Birth: (Month/Day/Year)	Social Security #:

Gender:
□ Male
□ Female

Marital Status:
□ Married □ Divorced
□ Separated □ Single
□ Widowed
□ Living with someone

Relationship:
□ Self □ Spouse
□ Child □ Brother/Sister
□ Grandchild □ Other _____
□ Parent _____

Ethnicity:

Do you consider yourself Hispanic/Latino?
□ Yes □ No
□ Unavailable/Unknown

Race:

Which category best describes your race?
□ Black or African American
□ Asian
□ White
□ Native Alaskan/American Indian
□ Native Hawaiian/other Pacific Islander
□ Mixed race
□ Unavailable/Unknown
□ Declined

Do you have a Family Doctor?
□ No
□ Yes-Doctor's Name_____
_____

My language preference is:
□ English □ Spanish
□ Other_____

My work status: (check all that apply)
□ Working □ Retired
□ Unemployed □ Going to school
□ Disabled? *If Yes,* Date: _____

Citizenship:
□ US Citizen
□ Permanent Resident
□ Temporary Alien
□ Refugee
□ Other_____

HEALTHCARE COVERAGE & INSURANCE INFORMATION FOR PERSON #1

			Currently Applying		
Insurance	**Yes Date Enrolled**	**No**	**Yes**	**No**	**Recently Denied - Date**
1. Employers Health Ins.	□ Reason:				
2. Medical Assistance					
3. Medicare A					
4. Medicare B					
5. Medicare Advantage Plan					
6. Veterans Benefits					
7. Other Private Insurance					
8. Health Insurance Marketplace					
Prescription Coverage					
a. SPBP or MH-IDD					
b. PACE/PACENET					
c. Employer					
d. Medicare Part D					
e. Health Insurance Marketplace					
f. Other					

HCN Use Only Location: _____Central Case Worker: _____

Approved: _____Denied: _____ Date: _____ HCC Effective Date _____

Discount: ___1A WS 100% - HH 100% -- ___1B WS 100% - HH 75% -- ___1C WS 100% - HH 50%

___2D WS 70% - HH 25% -- ___3E WS 40% - HH 0%

All information provided in this application will remain confidential

Client Authorization

By completing and submitting this application, I am applying for discounted service offered by the HealthyCare Card program through the Healthy Community Network. I understand that:

- ***HealthyCare Card is not health insurance or credible coverage.***
- ***My health care provider is giving me a discount for my care.***
- I give my consent to Healthy Community Network to request and receive information about my enrollment status with:

  ◦The Department of Public Welfare
  ◦The PACE or PACENET program
  ◦The Veterans Administration
  ◦ Pharmaceutical companies for medication assistance
  ◦ My employer

- I understand that this authorization *may expire six months to one year* after the agreement date and may be cancelled in writing by contacting the Healthy Community Network at 3421 Concord Road York, PA 17402 or by calling 800-429-2430.
- I must keep my doctor appointments. If I fail to keep appointments without notifying my healthcare provider, I may be dropped from the program.
- *I will do my part to maintain a positive and respectful relationship with health care providers, and all office staff.*
- **I agree to notify HealthyCare Card - Healthy Community Network if I, or a member of my family, should become eligible for any insurance program or if my or my family's income changes up or down. I understand that my membership may be stopped if I do not complete forms for other insurance coverage which I may be eligible for, including Medical Assistance and Medicare, if applicable.**
- I also give consent to share my personal health information with Healthy Community Network staff, so long as such information is used for my treatment, payment or health care operations. For example, information on any chronic diseases such as diabetes and heart disease may be used by my care team to better help me.
- I give permission to allow pharmaceutical companies or their designee to review my record for audit reasons if I get a medication through their patient assistance program.

I certify that the above information about my income, expenses and address is complete and accurate. I certify that the above information is true to the best of my knowledge and there is no attempt to commit fraud. I understand that I will be dropped from HealthyCare Card program if the above information is found to be false.

Patient Name _____ SSN ___-____-____ Date of Birth: _____

Signature _____Date _____

Relationship of Signer to Patient:_____

Application must be signed to process

After you turn in your application, it will be reviewed.

If approved, you will receive a plastic card in the mail. If not approved, you will receive notification in the mail.

All information provided in this application will remain confidential

HEALTHYCARE CARD

Today's Date: _____

MEDICAL INTAKE ASSESSMENT

Patient Name: _____ Date of Birth**:** _____

Social Security #: _____

Patient Phone #:_____

Do you have a Family Doctor? □ Yes Name of Doctor (or clinic) _____
□ No

Referred to HCN by: _____

Person Completing this Form:_____

I live with: _____

DO YOU HAVE:			**HAS ANY FAMILY MEMBER HAD:**		
Diabetes?	□ Yes	□ No	Diabetes?	□ Yes	□ No
Heart Failure (CHF)?	□ Yes	□ No	Heart Failure (CHF)?	□ Yes	□ No
Asthma?	□ Yes	□ No	Asthma?	□ Yes	□ No
A heart or circulation problem?	□ Yes	□ No	A heart or circulation problem?	□ Yes	□ No
COPD/Emphysema or Chronic Bronchitis	□ Yes	□ No	COPD/Emphysema or Chronic Bronchitis	□ Yes	□ No
Stroke	□ Yes	□ No	Stroke	□ Yes	□ No
Heart Disease	□ Yes	□ No	Heart Disease	□ Yes	□ No
Cancer	□ Yes	□ No	Cancer	□ Yes	□ No
Hypertension	□ Yes	□ No	Hypertension	□ Yes	□ No

WEIGHT: _____ **HEIGHT:** _____

MEDICATIONS: 1._____ 2._____ 3. _____
4._____5._____ 6._____

7. _____ 8. _____

HEALTH CONDITIONS (If none, write "None")

1._____

2._____

3._____

PAST SURGERIES (If none, write "None")

1._____

2._____

3._____

HOSPITALIZATIONS in past 5 years **(If none, write "None"):**

Date:_____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

TOBACCO USE: □ Yes □ No Amount/Day: _____

ALCOHOL USE: □ Yes □ No Amount/Day: _____

All information provided in this application will remain confidential