5. Person Applying #___

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 #___

			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