



www.scmsa.org

What is HealthAccess?

A Community Partnership designed to improve access to health care for low income, uninsured residents of Topeka/Shawnee County by combining donated physician care, hospital services, medication assistance.

Please call us with any questions you may have. Our staff is ready to help!
(785)235-0996

Applications can be emailed to haapp@stormontvail.org, mailed to PO Box 615 Topeka, KS 66601 or faxed to (785)235-2385

Patient Name: _____

Address: _____

Home Phone: _____ Work Phone: _____^{City} Cell Phone: _____^{Zip Code}

Date of Birth: _____ Age: _____ Gender: _____

Social Security Number _____ Email: _____

Question #1 is optional

1. Ethnicity: _____

2. Education Level: Less than high school High school graduate/GED
 Some College College Graduate

3. Are you a student, and under the age of 21? Yes No

4. Marital Status _____ Spouse Name: _____ Spouse DOB: _____

5. Please list everyone that lives in the household:

Name: _____ DOB: _____ Relationship: *self* _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

6. Housing (circle) Own, Rent, Stay with Friends/Family, Shelter, Other: _____

7. Are you currently employed? Yes No (last date of employment?) _____

Is your spouse employed? Yes No (last date of employment?) _____

8. Have you previously been enrolled in SCMS HealthAccess: Yes No

9. Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

10. Do you currently have private health insurance, including Oscar, Medicare, or Medicaid? ** Yes No

11. Have you ever received health insurance, including Medicaid benefits?
 Yes No If yes, when and why was it terminated? _____

12. Is it possible you will receive Medicare, KanCare/Medicaid, or health insurance?
 Yes No Please explain: _____

13. Do you currently receive assistance from any State Programs? Yes No
If yes, please describe: _____

14. Do you receive food stamps? Yes No

15. Do you have a military related disability **and** did you serve for at least 3 years?
 Yes No If yes, are you eligible for VA benefits? _____

16. Is this a work related injury? Yes No
If yes, have you applied for disability or worker's compensation? _____

17. Is there any legal action anticipated regarding injury or illness? Yes No

18. Do you receive any type of disability benefits? Yes No

19. Will your injury or illness prevent you from working for 12 months or longer?
 Yes No

** Any patient who electively withdraws from an insurance payor source (private health insurance, Medicaid, Marketplace, etc) may not enroll or re-enroll in HealthAccess for one (1) calendar year from the date of withdrawal.

Below is for office use only

KMAP Date Checked: _____

Medicaid Active? Yes No

The following page is **required** to be completed. If any part of this page is left blank, we will not be able to process your application.

20. A) Do you have a current primary care provider? Yes No (*must complete part B*)

If yes, please list name: _____

GraceMed Pine Ridge Health Center

B) (*only complete if you answered **no** above*)

All patients enrolled in HealthAccess are **required** to establish with a primary care provider. If you do not currently have one, you need to establish with a primary care provider prior to enrollment in HealthAccess. Most patients choose GraceMed (785-861-8800) or Pine Ridge Family Clinic (785-783-8453). Please make this appointment prior to submitting your HealthAccess application and indicate your choice below:

GraceMed Pine Ridge Health Center

First Appointment Date/Time: _____

If you do not schedule a new patient appointment with one of the clinics above, we cannot process your application until you do.

21. What is your gross monthly household income and source? _____

In the blanks below, please list all sources of income for the past 4 weeks for household:

	Name	Amount	Employer and How Often Paid
Paycheck(s)			
Tips			
Child Support			
Alimony			
Unemployment			
Worker's Compensation			
Pension			
Social Security			
SRS/Cash Assistance			
Other Income			

You must include proof of the previous four weeks of income with your application, this can be paycheck stubs or a letter from your employer. If you are self-employed, please provide proof of your previous months income, or your most recent tax return. If you do not have income, you must provide a letter of support from the person/agency supporting you. If you do not include this information with your application, we cannot process your application.

Program Overview

Doctors, area clinics, pharmacists, hospitals and many others are donating their services to help you get well and stay well. They are not being paid for the services provided to you. HealthAccess is not a government or an entitlement program. The donated care may end at any time, for any reason. HealthAccess does not include emergency room expenses or ambulance services. By signing this form you authorize HealthAccess to verify what you have reported during the application process, if you have provided false information that makes you ineligible for HealthAccess, you may be financially responsible for the donated care you received. You may also receive some bills, for which you are responsible, should you need services that are not donated to the HealthAccess program.

By signing this form you agree that you:

1. Will not schedule appointments with any doctor, clinic or hospital unless you have been referred there specifically.
2. Will follow your treatment plan.
3. Will promptly supply any information which may be requested by the program within the time frame requested.
4. Will allow all information regarding your participation in this program to be shared with other individuals, organizations and agencies at the discretion of SCMS HealthAccess in accordance with state and federal laws.
5. Will immediately contact SCMS HealthAccess if your income changes or you become covered by Medicare, Medicaid, private insurance, other health insurance or medical benefits.
6. Will apply for Medicaid, Healthwave or any other assistance programs if and when you are eligible.
7. Will authorize the State Department of Social and Rehabilitation Services to share information regarding your eligibility for Medicaid and other SRS programs with SCMS HealthAccess staff and with SCMS HealthAccess medical providers.
8. Will contact SCMS HealthAccess immediately with any changes in address or phone number.

Referrals

You agree to:

1. Keep each doctor's appointment. (if you miss 3 or more appointments in 12 months without letting the doctor's office know at least 24 hours before your appointment, you may be removed from the program.)
2. If you are unable to keep an appointment, **you** are responsible for notifying the doctor's office with whom you are scheduled, at least **24 hours in advance** to cancel and re-schedule.
3. Present your SCMS HealthAccess Patient I.D. card each time you see a doctor.
4. Call your SCMS HealthAccess doctor if you need to be seen anywhere else for care.

Medication Assistance

You understand that:

1. There is a 12 month maximum coverage of \$1,500 and a maximum cost of \$200 per prescription, unless funds are available and preauthorized by SCMS HealthAccess.
2. Most generic medications are available through this program. Your physician may be contacted and asked to use medications which are covered by the program.
3. A pharmacy may stop participating at any time, for any reason.
4. A co-pay per prescription will be required by your pharmacy.
5. You are to present your medication card each time you have a prescription filled.

Please Note

1. HealthAccess will not discriminate based on race, religion, color, sex, disability, age, national origin or ancestry, or in any other manner as described in state and federal guidelines.
2. HealthAccess does not provide medical care or services and does not make decisions regarding medical treatment plans. Those decisions remain between the providers and patients.
3. All voluntary providers are independent contractors; they are not considered agents or employees of HealthAccess.
4. HealthAccess is not responsible for bodily injury or negative outcomes potentially experienced within the provision of services by voluntary care providers. HealthAccess cannot guarantee the skill, care or training of voluntary providers

Disenrolling from a Payer Source

Any patient who electively withdraws from an insurance payor source (Medicaid/ Marketplace/ etc) may not enroll or re-enroll in HealthAccess for one (1) calendar year from the date of withdrawal.

By signing this form you confirm that you understand and agree to the above conditions and that the income information you provided is accurate. If you do not follow the above guidelines, you will be disenrolled from SCMS HealthAccess. Applicant Signature and Date (or Signature of Mother or Father of Applicant if Minor is under 18):

Signature

Date

Authorization Allowing Disclosure of Protected Health Information

I hereby authorize all health care providers providing services or treatment to me through the Shawnee County Medical Society Foundation Inc.'s HealthAccess Program to disclose information regarding all medical treatment regardless of format, *e.g.*, written, verbal, or electronic in the possession of such health care provider (hereinafter "office/hospital") to Shawnee County Medical Society and Shawnee County Medical Society Foundation, Inc., and to their agents, representatives, and employees, including, but not limited to, Blue Cross and Blue Shield of Kansas, Inc., the Kansas Department of Social and Rehabilitation Services, and their agents, representatives, and employees to manage, operate, and evaluate the HealthAccess Program. The Authorization will expire on my disenrollment from the HealthAccess Program.

I understand I have the right to revoke the Authorization by delivering such revocation in writing to the office. I understand Shawnee County Medical Society Foundation, Inc. may terminate my participation in HealthAccess if I revoke this Authorization.

Once the uses and disclosures have been made pursuant to this Authorization, they may be subject to redisclosure by any recipient and no longer protected by the federal privacy laws.

Participating healthcare providers will not condition treatment on my providing authorization for this use or disclosure. I understand, however, that the HealthAccess Program requires this signed Authorization prior to my being allowed to participate in the HealthAccess Program.

I understand that I may inspect or copy the protected health information to be used or disclosed under this Authorization. I understand I may refuse to sign the Authorization but that if I refuse to sign this Authorization, I may not be allowed to participate in HealthAccess. I understand that I will receive a copy of this Authorization if asked.

Patient Signature (if patient is a minor, the name of the minor is necessary)

Date

Signature of representative of application (if minor)

Relationship to minor

ENROLLMENT CHECKLIST

If you have not completed the below on this application, we will not be able to process your application:

- Have you completed **all 21** questions and **signed and dated** pages 4 and 5?
 Yes
- Have you submitted the households previous four weeks of income **or** a letter of support from the person or agency supporting you?
 Yes
- Have you filled out question 19, letting us know who your primary care provider is, or the date and time of your appointment at GraceMed or Pine Ridge?
 Yes