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

www.scmsha.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.

To Qualify for HealthAccess a you must -

1. Live in Shawnee County
2. Not be currently receiving Medicare, Medicaid, Kancare or other state/federal medical benefits or any other type of medical coverage/insurance
3. Have a gross family income that does not exceed 150% of the Federal Poverty Level Monthly 2023 Federal Guidelines

- Family of 1=$1,823
- Family of 2=$2,465
- Family of 3=$3,108
- Family of 4=$3, 750

To Enroll in HealthAccess, you must submit a completed application that includes -

1. Every part of this application completed, and your signature on the last two pages.
2. An identified Primary Care Provider in Shawnee County
3. Four weeks of Proof of Income, or a Letter of Support from the person or organization that supports you.

If any of these three things are missing we cannot process your application.

Applications can be emailed to haapp@stormontvail.org or faxed to (785)235-2385

- Once enrolled, your primary care provider will be your medical home regarding your healthcare needs. They will be able to prescribe you medications, and the HealthAccess program will help cover those costs with a **$5 co-pay.**
- HealthAccess will also assist your provider in finding you specialist care, if necessary.
- Please note, since HealthAccess focuses on preventive care, rather than emergency care, ER visits are not covered. If you become admitted, then the HealthAccess program charity care will start.

Updated 3/2023

SCMS HealthAccess Application

Submit your application via fax (785)235-2385, email haapp@stormontvail.org, or by mail to HealthAccess PO Box 615 Topeka, KS 66601

HealthAccess is a Community Partnership designed to improve access to health care for low income, uninsured residents of Topeka/Shawnee County. **Please note, if any portion of this is left blank, we cannot process your application**. Additionally, you must submit the household's previous 4 weeks of income, including wages, SSI, unemployment, child support, etc. If you do not have any income, you must submit a letter from the person or organization supporting you. This can include friends/family, Topeka Rescue Mission, Let's Help, KERA, etc. The letter must be signed and dated.

Updated 3/2023

Patient Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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: _____

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?) _____

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

9. Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

10. Do you currently have health insurance, 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. A) Medical History. Please give a history and names of physicians or health care providers that you have seen in the past. _____

_____

B) Have you been seen by any of the following health care providers in the last 12 months?

(please check all that apply)

☐ Hospital Emergency Room ☐ Urgent Care ☐ GraceMed ☐ Pine Ridge Health Center

☐ Cotton O'Neil Mobile Clinic

Name of Primary Care Provider: _____

*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), Pine Ridge Family Clinic (785-783-8453) or Cotton O'Neil Mobile Clinic (785-270-4440). Please make this appointment prior to submitting your HealthAccess application and indicate your choice above.*

20. Will your injury or illness prevent you from working for 12 months or longer?

☐ Yes ☐ No

I verify that the information in this application is correct and understand that it will be shared with my primary care provider to verify program eligibility.

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			
Paycheck			
Tips			
TAF			
Child Support			
Alimony			
Unemployment			
Worker's Compensation			
Pension			
Social Security			
SRS/Cash Assistance			
Other Income			

If you have no income, provide a written letter of support from the person or agency providing you support (parent/friend/family member/Let's Help, Section 8, Topeka Rescue Mission/etc.)

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*

PATIENT RESPONSIBILITIES FORM

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.

You agree that you:

1. Will not schedule appointments with any doctor, clinic or hospital other than the ones to which you have been referred.
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 reschedule.
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

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**