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**Please call us with any questions you may have.  
Our staff is ready to help!**

*This page is intended for the applicant to keep. Do not  
send in with your application.*



## **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 2025 Federal Guidelines
  - Family of 1=\$1,956
  - Family of 2=\$2,644
  - Family of 3=\$3,331
  - Family of 4=\$4,019

## **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](mailto: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.

# SCMS HealthAccess Application



Submit your application via fax (785)235-2385, email [haapp@stormontvail.org](mailto: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, etc. The letter must be signed and dated.

Updated 1/2025

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ City Work Phone: \_\_\_\_\_ Zip Code 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) Do you have a current primary care provider?  Yes  No

If yes, please list name or choose below: \_\_\_\_\_  
 GraceMed  Pine Ridge Health Center

B) (only if you have no 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) 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.***

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 all adults living in home:

	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.***

**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 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

**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