Action is required by you to remain qualified for the HealthAccess program!

Medical Home:

Dear HealthAccess Patient:

Enclosed is the re-application form for the SCMS HealthAccess program. All of the requested information and forms are required for you to re-qualify for the program. Please read carefully and follow the instructions. If you have questions about any of the requested information you may call the HealthAccess office at 235-0996.

Must be completed to remain qualified:

- ☐ Sign pages 2 (renewal application), 3 (Patient Responsibilities), and 4 (HIPAA release)
- ☐ Include last 4 weeks proof of income – paycheck stubs/unemployment benefits/social security/disability/etc.
  ****If you do not have income, but your spouse does, we will need your spouses income****

OR

- ☐ 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.)*

This can be submitted the following ways –

- Email to *haapp@stormontvail.org*
- Fax to *(785)235-2385*
- Mail to
  HealthAccess
  PO Box 615
  Topeka, KS 66601

Re-application does not guarantee that you will continue to qualify for the program. If you do not qualify you will receive a letter notifying you of the reasons why.

Please keep track of when your cards expire and remember that they will not be active beyond that date. Your cards will be active when you receive them in the mail.

Please remember to thank the doctors and nurses that have been caring for you. They are volunteering and donating their services to help you get well and stay well.

Thank You,
SCMS HealthAccess

For Office Use Only

☐ Dates of enrollment
______________to____________
☐ Disenrolled Reason:
____

HealthAccess Re-enrollment Form

Name:
Address:
ID #: RX ID #:
HealthAccess card effective dates:
Re-enrollment form mailed:
Application due to HealthAccess office (PO Box 615, Topeka, Kansas 66601) within two weeks. It may take 3-4 weeks after these forms are received to complete your re-enrollment.

Is the address above where you live? ☐Yes ☐No If no, please fill in your current address where you live:
____

Is your mailing address different? ☐No ☐Yes If yes, please list here:
____

What is your home telephone number? __________________
What is your cellular telephone number?_________________
What is your work telephone number? __________________

Do you have Medicare, Medicaid, HealthWave, or any type of state/federal medical benefit or private health insurance or a current workman's compensation claim or a health related insurance claim? No ____ Yes ____
(If yes, please explain.)_______________________________________

How many individuals currently live in your household? _______ Beginning with yourself, please list all below including their relationship to you. If they are new to your household since you last enrolled, please indicate when they entered your household.

Name	Date of Birth	Relationship
___________________	__________	Self
___________________	__________	___________________
___________________	__________	___________________
___________________	__________	___________________
___________________	__________	___________________
___________________	__________	___________________
___________________	__________	___________________
___________________	__________	___________________

Has the source of your income changed? ☐No ☐Yes (If yes, please tell us how.) ___________

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			

What is your total monthly gross income: $_______ (**Please attach proof of your income and proof of income for your spouse or parent of your children if they reside with you**. If you are self-employed please attach the 1040 and the Schedule C form from your most recent federal taxes.)

What is your social security number? ___________________________

If you receive Social Security benefits, when will you be eligible for Medicare? _________ Please attach proof from Social Security.

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.

____ _________

Applicant Signature (or signature of Mother or Father of applicant if minor is under 18) Date

1. Please collect your most recent check stubs (4 weeks) and make copies of them to return to HealthAccess. If you do not have check stubs, please provide written verification of the last four weeks gross income from the source of this income. If there is no income for the household, please provide a written statement(s) from the people who are supporting you, this must be signed and dated by them.

2. Please read, sign, and return the enclosed Patient Responsibilities form and Consent form, along with the income verification. The Patient Responsibilities form will be sent back to you with your updated ID cards if you still qualify, or you will receive a letter explaining why you are no longer eligible.

3. Please be sure you have attached appropriate postage and mail this form, proof of income, signed consent form, and signed patient responsibilities to:

SCMS HealthAccess
PO Box 615
Topeka, KS 66601-0615

Note: The HealthAccess office cannot make copies and is not staffed to accept hand delivered materials. You may also fax the application to 235-2385

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. This is not a government program, nor 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 not currently being donated for the HealthAccess program.

General 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, for example: get prescribed medicines and take as directed.
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 your enrollment site or 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 other assistance programs if and when you are eligible.
7. Will authorize the State Department for Children and Families 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.

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

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 will be disenrolled 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 the appointment.
3. Present your SCMS HealthAccess Patient I.D. card each time you see a doctor.
4. Call your enrollment site or SCMS HealthAccess doctor if you need to be seen anywhere else for care.

Medications Assistance

You understand that:

1. There is a 12 month maximum coverage of $1000, 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

- 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.
- 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.
- All voluntary providers are independent contractors; they are not considered agents or employees of HealthAccess.
- 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.

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 HealthAccess, and to their agents, representatives, and employees, including, but not limited to, Blue Cross and Blue Shield of Kansas, Inc., State of Kansas, GraceMed, Marian Dental Clinic, Stormont Vail Health*Care*, Inc., University of Kansas Health System St. Francis Campus, Pine Ridge Family Health Center, Washburn University School of Nursing and Student Health Services, Harvesters, Valeo, and their agents, representatives, and employees to manage, operate, and evaluate my eligibility for and participation in the HealthAccess Program. An exception to the above disclosure will be Substance Use Disorder treatment information protected under 42 CFR, Part 2. Disclosure of such information will require a release meeting the requirements specified within 42 CFR, Part 2.

This Authorization will expire on my disenrollment from the HealthAccess Program. I understand I have the right to revoke this Authorization at any time by delivering such revocation in writing to the HealthAccess Program office. Once the uses and disclosures of my information have been made pursuant to this Authorization, they may be subject to redisclosure by any recipient and are no longer controlled by this authorization and may not be protected by applicable state and federal privacy laws.

I understand that the HealthAccess Program requires this signed Authorization prior to my being allowed to participate in the Program. Therefore, I understand that the Shawnee County Medical Society Foundation, Inc. may terminate my participation in the HealthAccess Program if I revoke this Authorization. Participating healthcare providers will not condition the providing of healthcare treatment and/or services on my executing and/or agreeing to this Authorization.
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 the HealthAccess Program. I understand that I can receive a copy of this Authorization.

____
Applicant Signature **(if Patient is a Minor Under 18 years, the Name of the Minor is Necessary)**

____
Signature of Mother or Father or Personal Representative of Applicant if Minor is Under 18
Description of Representatives Authority to Act for Patient ______________________________________

Date: ________________________

SURVEY QUESTIONS: Please answer the following short survey questions:
1) Have you been to a Hospital Emergency Department in the last three months? Yes ___No ___

2) Did the medical care and prescriptions you received through HealthAccess help you get/stay well so that you could work? Yes___ No___ Does Not Apply ___

3) Do you believe your health is improving? Yes___ No___

4) Have you been able to fill your prescriptions? Yes___ No___ If no, why not?__________________

5) Do you have any additional comments?