New Patient Enrollment Application – Temporary Use Only

Please mail your completed application to HealthAccess, PO Box 615, Topeka, KS 66601 or fax to 785-235-2385. You must attach a copy of your households most recent 4 weeks of income. If there is no income, include a letter from the person supporting you. Our office number is 785-235-0996 if you have questions.

Patient Name: ____

Address: ____

Home Phone:_________ Work Phone:___________ Cell Phone: ____________

Date of Birth:____________ Age: _____________ Gender:_______________

Social Security #: ___________________

(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 age 21? Yes ☐ No ☐

4. Marital Status:__________ Spouse Name: __________ Spouse DOB: _________

5. Please list everyone that lives in the household?

Name: __________ DOB __________ Name: __________ DOB __________
Name: __________ DOB __________ Name: __________ DOB __________
Name: __________ DOB __________ Name: __________ DOB __________
Name: __________ DOB __________ Name: __________ DOB __________

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

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

8. Emergency Contact: ______________________________________

Home Phone: __________________ Work Phone: ___________________

9. Have you previously been enrolled in SCMS HealthAccess? Yes ☐ No ☐

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? No ☐ Yes ☐
If yes, have you applied for disability or worker's compensation? __________

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

18. Do you receive any type of disability benefits? Yes ☐ No ☐
If yes, please describe: ____

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)
Hosp. Em.Room ☐ Urgent Care Ctr ☐ GraceMed ☐
Name of Primary Care Provider ___________________________

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

21. What is your gross monthly household income and source? ___________________
Please attach copies of pay stubs for the last four weeks. If there is no income for the household, please attach a letter from someone who is supporting you.

____
Patient Signature Date

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 Stateof Kansas to share information regarding your eligibility for Medicaid and other 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.

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

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

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Date: ____________________________