



HealthyCare Card Application



This is an application for the HealthyCare Card, a program of Healthy Community Network.

The HealthyCare Card (HCC) is a community program which provides discounts to care for those who require financial assistance with their medical care. If you do not have health insurance- i.e. Medicaid, Medicare, State Exchange, or Employers insurance you will need to submit documentation.

The HealthyCare Card is not insurance or considered a "Qualified Health Plan" or "Credible Coverage."

Why are you applying?

- Medication assistance Ongoing health issues Outstanding medical bills Copay assistance
- Deductible: Amount \$ _____ Dental Other

Who referred you to Healthy Community Network? _____

I live with: _____

Instructions:

Below is a list of items needed for verification of your income and resources. Please be sure to complete the entire application & include copies of the following documentation:

- Federal 1040 Tax Return for most recent year (Required)**
 - For self-employment & investment income you must include Schedule 1, C, D & E when applicable.

I <u>did not</u> file Federal taxes last year.	
_____	_____
Signature	Date

- Current (consecutive weeks) pay stubs:
 - ___ Weekly: 4 pay stubs
 - ___ Bi-weekly: 3 pay stubs
 - ___ Monthly: 3 pay stubs
- Written explanation of all deposits over \$100 in bank accounts (excluding direct deposits and Social Security)
- 3 consecutive months of **ALL** checking and savings account statement showing **ALL** activity. Include all pages of each statement.
- If Self-employed: Copies of 6 months of all personal & business bank statements showing **ALL** activity.
- Most recent statement for retirement/investment accounts. (See Section 4)
- Copies of household bills if you have Medicare or will be Medicare eligible within one year (see Section 5)
Example: copy of electric bill, copy of rent/mortgage bill, heating bill and any other bills that you pay monthly

If marital status is separated, you must provide documentation of separation or include copies of spouse's income.

Please be advised failure to provide ALL required documentation prevents the application from being processed.

If you have questions or concerns ***800-429-2430 or email at hcn@wellspan.org***
www.healthycommunitynetwork.org

1. Person Applying #1:		How many people live in your house: ____	
Last Name		First Name	MI
Mailing Address:		City:	
State:	Zip Code	County	Phone number:
Date of Birth (Month/Day/Year)	Social Security #		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Living with someone	My work status (check all that apply): <input type="checkbox"/> Working <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Going to school <input type="checkbox"/> Disabled? <i>If Yes, Date: _____</i>		Citizenship: <input type="checkbox"/> US Citizen <input type="checkbox"/> Permanent Resident-(Resident since: _____) <input type="checkbox"/> Work Permit/DACA <input type="checkbox"/> Temporary Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Other _____

So we know how to serve you better with communication written and spoken would you answer the following questions:

<u>Do you have a Primary Care Provider?</u> <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____	<u>Which category best describes your race?</u> <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Alaskan/American Indian <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Mixed race <input type="checkbox"/> Unavailable/Unknown <input type="checkbox"/> Declined	<u>Do you consider yourself Hispanic/Latino?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unavailable/Unknown <u>Language Preference:</u> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
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2. Healthcare coverage & insurance information for Person #1					
Insurance	Yes Date Enrolled	No	Currently Applying		
			Yes	No	Recently Denied Date
1. Employers Health Ins.		<input type="checkbox"/> Reason: _____			
2. Medical Assistance					
3. Medicare A					
4. Medicare B					
5. Medicare Advantage Plan					
6. Veterans Benefits					
7. Other Private Insurance					
8. State Exchange					
Prescription Coverage					
a. SPBP or MH-IDD					
b. PACE/PACENET					
c. Employer					
d. Medicare Part D					
e. State Exchange					
f. Other					

Person 1 Applying

HCN Use Only

Approved: ____ Denied: ____ Date: ____ HCC Effective Date ____

Discount: ____1A WS 100% ____2E WS 70% ____40% Discount

FPL % ____ Outreach Specialist: ____

1. Person Applying #2:		How many people live in your house: _____	
Last Name		First Name	MI
Mailing Address:		City:	
State:	Zip Code	County	Phone number:
Date of Birth (Month/Day/Year)	Social Security #	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Living with someone	My work status (check all that apply): <input type="checkbox"/> Working <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Going to school <input type="checkbox"/> Disabled? If Yes, Date: _____	Citizenship: <input type="checkbox"/> US Citizen <input type="checkbox"/> Permanent Resident-(Resident since: _____) <input type="checkbox"/> Work Permitted/DACA <input type="checkbox"/> Temporary Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Other _____	

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2. Healthcare coverage & insurance information for Person #2					
Insurance	Yes Date Enrolled	No	Currently Applying		
			Yes	No	Recently Denied Date
1. Employers Health Ins.		<input type="checkbox"/> Reason: _____			
2. Medical Assistance					
3. Medicare A					
4. Medicare B					
5. Medicare Advantage Plan					
6. Veterans Benefits					
7. Other Private Insurance					
8. State Exchange					
Prescription Coverage					
a. SPBP or MH-IDD					
b. PACE/PACENET					
c. Employer					
d. Medicare Part D					
e. State Exchange					
f. Other					

Person 2 Applying

HCN Use Only
 Approved: _____ Denied: _____ Date: _____ HCC Effective Date _____
 Discount: _____1A WS 100% _____2E WS 70% _____40% Discount
 FPL % _____ Outreach Specialist: _____

3. Household Gross Income: Write in dollar amounts and attach copies of income.					
Source	Wages	Gross amount Per pay	How often is this income received		Who receives the income
Employer Name:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	<input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month	
Employer Name:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	<input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month	
Unemployment		\$	Include a copy of Benefit Letter		
Child Support/Alimony		\$	Include a copy of Benefit Letter		
Workman's Comp		\$	Include a copy of Benefit Letter		
Disability/Social Security		\$	Include a copy of Benefit Letter		
Pension		\$	Include a copy of Benefit Letter		
Investment/Rental Property Income		\$	Include a copy of Benefit Letter		
Public Assistance (Cash and food stamps)		\$	Include a copy of Benefit Letter		
Other		\$	Include a copy of Benefit Letter		
TOTAL:		\$			

If you have no income for the last 30 days, please call 1-800-429-2430

4. Household Asset Information: Include ALL pages of most recent 3 months bank statements for each account, Self-employed the most recent 6 months bank statements for each account.			
Asset:	Current Balance:	Who owns the asset	
Checking Account Balance*	\$	<input type="checkbox"/> No Account	
Savings Account Balance*	\$	<input type="checkbox"/> No Account	
Other (Ex: Christmas Club, Vacation Club)	\$	<input type="checkbox"/> No Account	
401(K) and 403 (b)	\$	<input type="checkbox"/> No Account	
IRA or other retirement plans	\$	<input type="checkbox"/> No Account	
Money Market	\$	<input type="checkbox"/> No Account	
Certificate of Deposit (CD)	\$	<input type="checkbox"/> No Account	
Other Investments (Ex: stocks, bonds, trust funds)	\$	<input type="checkbox"/> No Account	

* Written explanation of all deposits over \$100 in bank accounts (excluding direct deposits and Social Security)

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If you have questions or concerns:  **800-429-2430 or email hcn@wellspan.org**
www.healthycommunitynetwork.org

5. Household Expense Information:

Photocopies of most recent monthly bills are required **ONLY IF** you have Medicare or you are going to be eligible for Medicare within a year

Expense:	Creditor Name:	Amount
Rent/Mortgage		
Lot Rent		
Utilities:		
Gas		
Electric		
Oil		
Phone/Cell		
Water/Sewer		
Garbage		
Insurance:		
Life		
Health		
Auto		
Home		
Taxes:		
Property		
School		
Loans		
Other:		

If you have questions or concerns:  800-429-2430 or email hcn@wellspan.org

www.healthycommunitynetwork.org

Client Authorization

By completing and submitting this application, I am applying for discounted service offered by the HealthyCare Card program through the Healthy Community Network. I understand that:

- **HealthyCare Card is a financial assistance program for medical care and not health insurance.**
- I give my consent to Healthy Community Network to request and receive information about my enrollment status with:
 - PA Department of Human Services/County Assistance Office
 - The PACE or PACENET program
 - Pharmaceutical companies for medication assistance
 - Another participating healthcare provider for financial assistance help for you.
 - The Veterans Administration ◦ My employer
- I understand that this authorization *may expire six months to one year* after the agreement date and may be cancelled in writing by contacting the Healthy Community Network at 3421 Concord Road York, PA 17402 or by calling 800-429-2430.
- *I will do my part to maintain a positive and respectful relationship with health care providers, and all office staff.*
- **I agree to notify HealthyCare Card - Healthy Community Network if I, or a member of my family, should become eligible for any insurance program or if my or my family's income changes up or down. I understand that my membership may be stopped if I do not complete forms for other insurance coverage which I may be eligible for, including Medical Assistance and Medicare, if applicable.**
- I also give consent to share my personal health information with Healthy Community Network staff, so long as such information is used for my treatment, payment or health care operations. For example, information on any chronic diseases such as diabetes and heart disease may be used by my care team to better help me.
- I give permission to allow pharmaceutical companies or their designee to review my record for audit reasons if I get a medication through their patient assistance program.

I certify that the above information about my income, assets, expenses and address is complete and accurate. I certify that the above information is true to the best of my knowledge and there is no attempt to commit fraud. I understand that I will be dropped from HealthyCare Card program if the above information is found to be false.

Person Applying #1

Name _____ SSN _____ - _____ - _____ Date of Birth: _____

Signature _____ Date _____

Relationship of Signer to Patient: _____

Person Applying #2

Name _____ SSN _____ - _____ - _____ Date of Birth: _____

Signature _____ Date _____

Relationship of Signer to Patient: _____

Application must be signed to process

After you turn in your application, it will be reviewed. You will be notified by mail of the determination.

Send completed application with copies of all required documentation to:

By mail - Healthy Community Network 116 S. George Street, Suite 101, York, PA 17401

By fax – 717-848-2029

Email – hcn@wellspan.org and attach to an email

If you have questions or concerns  800-429-2430 or email at hcn@wellspan.org
www.healthycommunitynetwork.org

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