HEALTHY COMMUNITY NETWORK

HealthyCare Card Application – one additional person applying with a family

WELLSPAN HEALTH

1. Person Applying #__: 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: □ Male □ Female □ Declined

Marital Status:
□ Married □ Divorced
□ Separated □ Single
□ Widowed
□ Living with someone

My work status (check all that apply):
□ Working □ Retired
□ Unemployed □ Going to school
□ Disabled? *If Yes,* Date: _____

Citizenship:
□ US Citizen
□ Permanent Resident-(Resident since: _____)
□ Work Permit/DACA
□ Temporary Alien
□ Refugee
□ Other_____

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

Do you have a Primary Care Provider?

□ No
□ Yes
Name: _____

Which category best describes your race?

□ Black or African American
□ Asian
□ White
□ Native Alaskan/American Indian
□ Native Hawaiian/other Pacific Islander
□ Mixed race
□ Unavailable/Unknown
□ Declined

Do you consider yourself Hispanic/Latino?

□ Yes □ No
□ Unavailable/Unknown

Language Preference:

□ English □ Spanish
□ Other_____

2. Healthcare coverage & insurance information for Person #__

			Currently Applying		
Insurance	**Yes** Date Enrolled	**No**	**Yes**	**No**	**Recently** Denied Date
1. Employers Health Ins.		□ 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 __ Applying

HCN Use Only

Approved: _____ Denied: _____ Date: _____ HCC Effective Date _____

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

FPL %_____ Outreach Specialist: _____

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 #__

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 <u>all required documentation</u> 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 hcn@wellspan.org
www.healthycommunitynetwork.org

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