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, Marketplace, 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:

Use the list below and check off the copies included with this application

☐ **Federal 1040 Tax Return for most recent year (Required)**

- For self-employment & investment income you must include Schedule C, D & E when applicable.

I did not file taxes last year.

_____

Signature *Date*

☐ Current (consecutive weeks) pay stubs:
- ___ Weekly: 4 pay stubs
- ___ Bi-weekly: 3 pay stubs
- ___ Monthly: 3 pay stubs

☐ Unemployment Benefit Letter

☐ Child Support Income, Spousal Support

☐ Public Assistance, SNAP Eligibility Letter

☐ Social Security & Pension Statements for current year

☐ Workers Compensation/Disability

☐ Provide a copy of Photo ID

☐ Copy of all medical & prescription insurance cards

☐ 3 consecutive months of **ALL** checking and savings account statement showing all deposits. Include all pages of each statement.

☐ If Self-employed: Copies of 6 months of all personal & business bank accounts

☐ 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.*

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

Questions or concerns - Call 800-429-2430.

Revised 6/2018

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: □ 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
□ Temporary Alien
□ Refugee
□ Other_____

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

Language Preference:
□ English □ Spanish
□ Other_____

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

2. Healthcare coverage & insurance information for Person #1

			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. Health Insurance Marketplace					
Prescription Coverage					
a. SPBP or MH-IDD					
b. PACE/PACENET					
c. Employer					
d. Medicare Part D					
e. Health Insurance Marketplace					
f. Other					

Person 1 Applying

HCN Use Only Location: _____Central Case Worker: _____

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

Discount: ___1A WS 100% - HH 100% -- ___1B WS 100% - HH 75% -- ___1C WS 100% - HH 50%

___2D WS 70% - HH 25% -- ___3E WS 40% - HH 0%

1. Person Applying #2

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
□ Temporary Alien
□ Refugee
□ Other_____

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

Language Preference:
□ English □ Spanish
□ Other_____

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

2. Healthcare coverage & insurance information for Person #2

			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. Health Insurance Marketplace					
Prescription Coverage					
a. SPBP or MH-IDD					
b. PACE/PACENET					
c. Employer					
d. Medicare Part D					
e. Health Insurance Marketplace					
f. Other					

Person 2 Applying

HCN Use Only Location: _____Central Case Worker: _____

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

Discount: ___1A WS 100% - HH 100% -- ___1B WS 100% - HH 75% -- ___1C WS 100% - HH 50%

___2D WS 70% - HH 25% -- ___3E WS 40% - HH 0%

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:	□ Full time □ Part time □ Seasonal	$	□ Weekly □ Every 2 Weeks □ Monthly □ Twice Per Month □ Annually	
Employer Name:	□ Full time □ Part time □ Seasonal	$	□ Weekly □ Every 2 Weeks □ Monthly □ Twice Per Month □ Annually	
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 717-812-2990 (York) or 717-339-2439 (Gettysburg)

4. Household Asset Information:	**Include <u>all</u> 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		$	□ No Account	
Savings Account Balance		$	□ No Account	
Other (Ex: Christmas Club, Vacation Club)		$	□ No Account	
401(K) and 403 (b)		$	□ No Account	
IRA or other retirement plans		$	□ No Account	
Money Market		$	□ No Account	
Certificate of Deposit (CD)		$	□ No Account	
Other Investments (Ex: stocks, bonds, trust funds)		$	□ No Account	

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

If you have questions or concerns  ***800-429-2430.***

5. Household Expense Information:		
Photocopies of monthly bills are required if you have Medicare or you are going to be eligible in the next 12 months		
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.***

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:
  - ◦The Department of Public Welfare
  - ◦The PACE or PACENET program
  - ◦The Veterans Administration
  - ◦ Pharmaceutical companies for medication assistance
  - ◦ Another participating healthcare provider for financial assistance help for you.
  - ◦ 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, 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 <u>all required documentation</u> before mailing envelope to:

<u>In Ephrata, Lebanon, and York County:</u> ***or*** ***<u>In Adams County:</u>***

Healthy Community Network
116 S. George Street, Suite 101
York, PA 17401
Local number: 717-812-2990

Healthy Community Network
39 N. Fifth Street
Gettysburg, PA 17325
Local number: 717-339-2439