

Hope Within Community Health Center

To process your application on a timely basis, we **must** have the following information:

- Proof of ID (Copy of Driver's license or ID card)
- Proof of Residency (Copy of current bill with address)
- Proof of Income or Living Statement (If you are not employed or have no income, please request a Living Statement from Hope Within)
- Most recent Tax Return (1040 or 1040EZ)

Incomplete applications will be returned!

Eligibility Application

Personal Information

Name _____ Social Security # _____ Date of Birth: _____

Address _____ County _____ Race: _____

Phone: Home _____ Work _____ Cell _____ Are you a U.S Citizen? Yes No

Other contact person _____ Phone: _____

(this person will be given permission to discuss your financial and/or medical information with Hope Within staff and volunteers)

How did you find out about Hope Within Community Health Center? _____

Health Insurance Information

Did you have Medical Assistance in the last 6 months? Yes No

Do you receive any of the following? {Mark all that apply}

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	<input type="checkbox"/>	Are you a veteran? % of disability _____
<input type="checkbox"/>	<input type="checkbox"/>	Medical Assistance	<input type="checkbox"/>	<input type="checkbox"/>	Private Insurance? Company _____
<input type="checkbox"/>	<input type="checkbox"/>	Workman's Comp	<input type="checkbox"/>	<input type="checkbox"/>	VA Medical benefits
<input type="checkbox"/>	<input type="checkbox"/>	Adult Basic/CHIP	<input type="checkbox"/>	<input type="checkbox"/>	Auto accident medical claims pending
<input type="checkbox"/>	<input type="checkbox"/>	Other government program (i.e. OVR, state black lung program, others)			(are you being represented by an attorney for this accident)

Do you participate in a cooperative medical coverage program of any kind? i.e. Samaritan Ministries, Medi-Share Yes No

Do you have any medical problem that keeps you from getting or keeping a job? Yes No

Explain _____

Employment Information

Patient's Occupation _____ Employer _____ How long employed _____

Employer address _____ Phone # _____

Hours Full time Part time Hours per week _____ Hourly rate _____

Are there any health insurance benefits pending? Yes No If yes, when? _____

How will you cover costs NOT covered by Hope Within Community Health Center? {x-rays, labs, medications}

Financial Income Information

Your monthly Income

_____ Gross Income
_____ Child Support
_____ TANF (*Temporary Assistance to Needy Families*)
_____ Disability
_____ Retirement

Income from others in your household

_____ Gross Income
_____ Child Support
_____ TANF
_____ Disability
_____ Retirement

_____ VA Pension	_____ VA Pension
_____ Social Security	_____ Social Security
_____ Food Stamps/WIC	_____ Food Stamps/WIC
_____ Sectional 8 Housing	_____ Sectional 8 Housing
_____ Investment Income {CDs, rental property, etc }	_____ Investment Income
_____ Unemployment	_____ Unemployment
_____ Workman's Compensation	_____ Workman's Comp.
_____ Educational Grants/Loans	_____ Educational Grants/Loans
_____ Estate Income	_____ Estate Income
\$ _____ Sub-total	Sub-total \$ _____ Total \$ _____

All other household income {i.e. Family support, estate and liability income} _____
 List other assets {checking/savings account balances} _____

Household Information

Did patient file last year's income tax return? Yes No

Number of dependants that YOU are responsible for {include self} based on Federal income tax return.

Name	Age	SS#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total number in household: _____

**** PROOF OF RESIDENCY AND INCOME ARE REQUIRED FOR THIS APPLICATION TO BE PROCESSED****

Eligibility Yes or No **PALCO Eligible** Yes or No

Comments/Extenuating circumstances:

If not eligible for Hope Within services, patient referred to: _____ Date _____

Limited Liability Policy

To be provided to the patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as we are able or to a parent or legal guardian when the patient lacks legal responsibility for his/her care.

By Federal law, the Federal Tort Claims Act (FTCA) allows the Department of Health and Human Services to be the primary provider of malpractice insurance in regards to any negative effects from personal injury or death resulting from any health care provisions from our free clinic staff and volunteers. Our providers are basically seen as employees of the Public Health Service. The malpractice coverage also applies to any of our board members, staff, or volunteers that provide care at our office or other events sponsored by our health center.

Acknowledged:

_____ (Patient signature) _____ (Patient name printed)

Date: _____

Certification

I recognize that other people are donating their time and money so that I can receive free health care and I am thankful for this help. I do certify that the above financial information is correct and give my permission to verify income from any or all of the above sources. I understand that false information will result in denial of services.

Signature _____ **Date** _____

Information release

I release the above listed contact person to discuss financial and medical information to Hope Within Community Health Center.

Signature _____ **Date** _____

Hope Within Community Health Center is a resource for qualifying patients to obtain medication from Patient Assistance Programs sponsored by large pharmaceutical companies. When a patient meets the Hope Within eligibility requirements, your Advocate applies at regular intervals to these companies on the patient's behalf to obtain prescription medication. In most cases, the patient's signature is required, and in all cases the prescribing physician's signature is required on each application form.

By signing this agreement, you, the patient, give your permission to Hope Within Community Health Center staff, to sign your name on your order form(s). Your name will be signed only on medication orders that are specifically for you, as prescribed by your physician.

AGREEMENT:

I hereby give permission to Hope Within Community Health Center, to sign my name to Patient Assistance applications for medications prescribed by my physician. I understand that I may revoke this agreement at any time and assume responsibility for signing my own forms.

I give permission for Hope Within to send needed medical or financial information to referred organizations for patient assistance programs

Your signature allows HW to collect the necessary information, process, share and forward your request for medications to the pharmaceutical companies. Your signature also authorizes HW to complete, sign and execute PAP applications on your behalf, which will shorten the application process and expedite delivery of medication for you. **If you provide incorrect information, you will be held responsible.**

Full name of patient (please print)

Patient or Legal Representative Signature Date

Witness (Representative of Hope Within) (Please Print)

Witness (Representative of Hope Within) (Signature) Date

*Please Return To:
4748 E. Harrisburg Pike
Elizabethtown, PA 17022
(717) 367-9797*