Hope Within Ministries

Community Health Center | Counseling Services

4748 E. Harrisburg Pike • Elizabethtown, PA 17022 • 717-367-9797

Hope Within Community Health Center

PATIENT ELIGIBILITY APPLICATION

Please complete a separate application for each person applying **Date: _____**

Last Name, First Name, Full Middle Name		Gender (Male/Female)	Social Security Number	
Address		City	State	Zip Code
Home Phone	Work Phone		Cell Phone	
Date of Birth (mm/dd/yyyy)	Emergency Contact Name and Phone			

1. Who referred you to Hope Within? _____	
2. Are you applying for or receiving Supplemental Security Income (SSI)?	Yes ___ No ___
3. Do you have Medical Assistance through the Welfare Office? a. If no, did you have Medical Assistance in the last 6 months? b. If yes, list the reason for termination: _____	Yes ___ No ___ Yes ___ No ___
4. Do you have a Medical Assistance application pending? a. If yes, what date did you submit the application? _____	Yes ___ No ___
5. Have you been denied for a Medical Assistance application you submitted? a. If yes, what is the date you were you denied? _____	Yes ___ No ___
6. Do you have any other type of health insurance?	Yes ___ No ___
7. Do you have Medicare through Social Security?	Yes ___ No ___
8. Are you a veteran? a. If yes, do you receive Veterans' Benefits?	Yes ___ No ___ Yes ___ No ___
9. Are you a spouse or widow of veteran? a. If yes, do you receive Veterans' Benefits?	Yes ___ No ___ Yes ___ No ___
10. What is your citizenship status? U.S. Citizen ___ Perm. Alien ___ Temp. Alien ___ Refugee/Asylee ___ Other ___	

11. Do you have a medical problem that keeps you from getting or keeping a job?	Yes ___ No ___
12. Are you applying for or receiving Social Security Disability (SSD)? a. If yes, what date did (or will) your benefits begin? _____	Yes ___ No ___
13. Are you being seen due to a work-related accident or illness?	Yes ___ No ___
14. Do you desire to be seen for injuries related to an automobile accident? If yes, are you represented by an attorney?	Yes ___ No ___ Yes ___ No ___
15. What is your monthly gross income from all sources? $ _____	
16. How many family members (including you) live in your household? _____	
17. What is your marital Status? Married ____ Single ____ Divorced ____ Widow/Widower ____ Other ____	
18. Do you have children under 21 living in your home? a. If no, are your resources (cash, bank accts, IRA's, etc.) less than $2,000?	Yes ___ No ___ Yes ___ No ___
19. Are you or anyone who lives with you pregnant?	Yes ___ No ___
20. Do you require health-sustaining medications?	Yes ___ No ___
21. Do you have any unpaid medical bills from the last 3 months? a. If yes, what is the approximate dollar amount? $_____	Yes ___ No ___
22. Who is your primary care physician? _____ a. Name of Practice and Site: _____	
23. Are you currently a resident of Dauphin, Lancaster or Lebanon County?	Yes ___ No ___
24. What is your Race/Ethnicity? African-American ___ Asian/Pac Islander ___ Caucasian ___ Hispanic ___ Other ___	
25. What language do you prefer? _____	
26. List any barriers to appointments with providers (e.g., outstanding bills, termination, lack of transportation, no English spoken, etc): _____ _____	
27. Are you employed? a. If yes, where? _____ b. If no, list date of last employment _____	Yes ___ No ___
28. Does your work place offer health Insurance? a. If yes, how much would it cost per month? $_____	Yes ___ No ___

29. Do you need a Translator?	Yes ___ No ___
30. Do you need assistance with Transportation?	Yes ___ No ___

INCOME: List amount of Monthly Gross Income (before taxes and deductions)

	Salary/ Wages	Social Security/ SSI	Disability	Unemploy-ment	Worker's Comp	Pension/ Retire-ment	Self-Employ-ment	Child Support/ Alimony	Other Income
Self	$	$	$	$	$	$	$	$	$
Spouse	$	$	$	$	$	$	$	$	$
Child (under 18)	$	$	$	$	$	$	$	$	$
Child (under 18)	$	$	$	$	$	$	$	$	$
Other	$	$	$	$	$	$	$	$	$

Total Monthly Gross Income: $ _____

Total in Checking/Savings: $ _____

If you have no income, please explain how your basic needs are being met:

_____
_____
_____
_____

HOUSEHOLD INFORMATION

Last name, First Name, Middle Initial		Gender (M/F)	Date of Birth	Marital Status	Social Security Number	Relation to Applicant	Citizenship Status	Lived in Lancaster, Dauphin or Lebanon Co. for more than 3 months

PROOF OF IDENTIFICATION, RESIDENCY, AND INCOME

Note: You are required to submit proofs of your Identification, Residency and Income along with this Eligibility Application. *See the last page ("Acceptable Proofs of Eligibility") for instructions.* **PATIENT AGREEMENTS**

A. General Agreements:

- I have attached the acceptable proofs of eligibility that are outlined in this application.
- I certify with my signature below, that the above information is a full and complete disclosure of my income and address. 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 appropriate action will be taken if the above information is found to be false.
- I recognize that other people are donating their time and their money so that I may receive free health care. I am grateful for their help. I certify with my signature below, that the financial information I have provided with this application is correct. I give my permission for Hope Within to verify what I have stated with any of the sources mentioned above.
- I recognize that Hope Within Community Health Center has limited liability malpractice coverage. The coverage at Hope Within is provided under the FTCA (Federal Tort Claims Act). This coverage allows the Department of Health and Human Services to be the primary provider of malpractice insurance in regard to any negative effects from volunteers. Hope Within's providers are essentially viewed as employees of the public health service. The malpractice coverage also applies to any of Hope Within's board members, staff, or volunteers that provide care at our office or other events sponsored by our health center.
- I recognize that the Hope Within healthcare professionals strive to treat me according to what is in my best health interests. If there is ever a situation where I strongly desire a certain treatment that my provider does not feel is healthy for me, I recognize that I may not be able to receive this treatment from Hope Within. I also realize that there are other health centers in both Dauphin, Lancaster and Lebanon Counties where I could receive care, even without health insurance.

B.

Applicant Signature	Date

Information release

From time to time, Hope Within may need to contact me. If I am not available**, I authorize the following contact person(s) to discuss my financial and/or medical information to/with Hope Within Community Health Center:**

My Contact Person(s): _____ (print name)

_____ (print name)

C.

Applicant Signature	Date

Patient Assistance Programs (PAPs) Agreements

Hope Within Community Health Center is also a resource for qualifying patients to obtain medication from Patient Assistance Programs (PAPs) 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 patients' signature is required, and in all cases, the prescribing physician's signature is required on each application. I hereby:

- Give my permission to Hope Within Community Health Center to sign my name to PAP applications for medications prescribed for me by my physician. I understand that I may revoke this authorization at any time. I will then assume responsibility for signing my own forms.
- Give my permission for Hope Within to send the required medical or financial supporting documentation to the referred organizations for the PAP programs.
- Give my permission for these PAP-related pharmaceutical companies to run credit checks on me as needed in order to secure medications I may require.
- Give my permission to Hope Within Community Health Center to collect the necessary information, process, share and forward my request for medications to pharmaceutical companies. My signature also authorizes Hope Within to complete, sign and execute PAP applications on my behalf. **If I provide incorrect information, I will be held responsible.**

D.

Applicant Signature	Date

Conclusion

_____	_____	_____
Signature of patient (or legal representative)	Printed Name	Date
_____	_____	_____
Signature of Hope Within representative	Printed Name	Date

Please Return this Completed Application to:

Hope Within Community Health Center
4748 East Harrisburg Pike
Elizabethtown, PA 17022
717-367-9797 phone
717-367-1160 fax

ACCEPTABLE PROOFS OF ELIGIBILITY

You are required to submit proofs of your identification, Residency and Income. Attach photocopies of the required documentation to this Application.

Note: Only send photocopies. Do not send Originals. They will not be returned.

Acceptable Proofs of Identification (provide one of the following documents below)

- Copy of valid PA driver's license or PA ID card (can also serve as proof of Residence if address is current)
- Copy of passport
- Copy of Alien Registration card

Acceptable Proofs of Residency (Provide one of the following documents below)

- Copy of valid PA driver's license or PA ID card (can also serve as proof of Identification if address is current)
- Copy of utility bills
- Copy of rent receipt or written statement from a non-relative landlord
- Copy of mortgage receipt
- Envelope of mail postmarked within the last 3 months with applicant's name and address

Acceptable Proofs of Income (provide one document ***for each type of income*** for your monthly gross income)

- Copy of pay stubs, checks, and award letters from the last 30 days
- Copy of Social Security award letter
- Copy of Worker's Comp check, check stub or current award notice
- Copy of award statement for unemployment
- Copy of pension award letter
- A written statement from person or agency providing money or making payments for you
- If you are self employed, we need your estimated income and expenses for the last quarter and a copy of last year's federal tax return
- Copy of the most recent year's tax return