



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			
E-Mail Address		County of residence?			

1. How were you referred you to Hope Within? _____	
2. Do you have health insurance of any type; including Medical Assistance, Medicare, Veteran's Benefits, personal healing policy or cost sharing? If yes: Please explain your plan. _____ _____	Yes ___ No ___
3. Is your request to be seen due to a work related injury or motor VA If yes, please explain. _____	Yes ___ No ___
4. What is your marital Status? Married ___ Single ___ Divorced ___ Widow/Widower ___ Other ___	
5. What is your citizenship status? U.S. Citizen ___ Perm. Alien ___ Temp. Alien ___ Refugee/Asylee ___ Other ___	
6. What is your Race/Ethnicity? African-American ___ Asian/Pac Islander ___ Caucasian ___ Hispanic ___ Other ___	
7. What is your monthly gross income from all sources? Please include wages, tips, unemployment, social security, disability, retirement, alimony, capital gains, investments, royalty, rental \$ _____	

Patient Assistance Programs (PAPs) Agreements

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 and Lancaster Counties where I could receive care, even without health insurance.

B.

Applicant Signature	Date
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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
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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. 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