



| |
|----------------------------------|
| <input type="checkbox"/> Medical |
| <input type="checkbox"/> Dental |

Application for Enrollment

DIRECTIONS! Please submit the following with your completed application: **1) Proof of income** (A copy of the first page of last year's federal income tax statement (IRS 1040, 1040A or 1040EZ), or a copy of your W-2 Earning Statements for last year, or two most recent earning statement). **2) Proof of Utah County Residency** (i.e. lease agreement, utility bill, etc.) **3) \$20 membership fee** (good for 6 months).

- Qualified patients will be eligible for services for 6 months, and then will be required to renew application with updated income verification and renewal of membership fee.

APPLICANT INFORMATION

| | | | | | | |
|---|-------|--------|--|--------------------------------------|--|----------------------------------|
| Name: Last | First | Middle | Age: | Date of Birth: (mo/day/yr) / / | Sex: M <input type="checkbox"/> F <input type="checkbox"/> | Social Security No. or ITIN No.: |
| Address: Street | City | State | Zip | County | Phone Number | |
| How long has the applicant lived in Utah? | | | Marital Status: __Single __Married __Divorced __Separated __Widowed | | | |

HOUSEHOLD INFORMATION

| | | | | |
|---|---------------------|--------|--|--------------------------------|
| Responsible Party: (if different from above) Last | First | Middle | Current Individual Gross Monthly Income: | Relationship to Applicant: |
| Employer's Name or date of last employment: | Employer's Address: | | | Work Number () |
| Spouse's Name (if applicable): Last | First | Middle | Spouse's Employer's Name: | |
| Spouse's Employer's Address: | | | Spouse's Gross Monthly Income: | Spouse's Work Number () |
| Are you or your spouse receiving: (Please check all that apply) <input type="checkbox"/> Workers Compensation <input type="checkbox"/> SSI/SSA <input type="checkbox"/> Unemployment <input type="checkbox"/> Disability Amount \$ _____ per month/year | | | Are you receiving child support? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____ per month/year | |
| Is there any other source of household income? If so, please list the source and amount: | | | TOTAL GROSS MONTHLY HOUSEHOLD INCOME: | |
| Do you or the applicant have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name insurance company | | | Do you or the applicant have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name insurance company | |
| Are you or your children on CHIP, Medicaid or PCN? If yes, list individuals and type of coverage. | | | Have you or your children ever been denied application for CHIP, Medicaid, or PCN? Please explain: | |
| Email address where we can contact you: | | | Number of Children in Household : | Number of Adults in Household: |

ALTERNATE CONTACT (Must be different than patient's contact information)

| | | | | | |
|---------------------|-------|--------|-----|--------|----------------------------------|
| Contact Name : Last | First | Middle | | | |
| Address: Street | City | State | Zip | County | Phone Number (include area code) |

FOR OFFICE USE ONLY

| | | | | | |
|---|--|---|--|--|---|
| Date Received: _____ | By (Initials): _____ | Poverty Level _____ | Eligible / Ineligible | | |
| <input type="checkbox"/> Application Complete | <input type="checkbox"/> Photo Taken | <input type="checkbox"/> \$20 collected | <input type="checkbox"/> Referral Provided | <input type="checkbox"/> Income Verification | <input type="checkbox"/> Address Verification |
| <input type="checkbox"/> Copy of Patient Responsibilities | <input type="checkbox"/> New Patient Checklist Started | | | | |

DEMOGRAPHIC INFORMATION (optional)

1. How did the applicant hear about Community Health Connect?

- Volunteer Care Clinic Mountainlands CHC Client School Nurse
- Health Department Food & Care Coalition Health Clinics of Utah
- Clergy Doctor or Dentist Name: _____ Other _____

2. Ethnic Origin (check one): Native American or Alaskan Native Asian/Pacific Islander

- Hispanic White Black Other (please specify) _____

3. Religious Affiliation (check one):

- Lutheran Catholic Mormon Jewish Methodist
- Presbyterian Baptist Episcopal United Church of Christ
- Other _____

4. Is applicant a United States Citizen or Legal Resident? Citizen Resident Other

5. Level of Education: College High school Elementary School Other _____

MEDICAL OR DENTAL CONCERN

What is the Specific Medical or Dental concern(s) for which you are seeking treatment through Community Health Connect?

Do you need an interpreter for your medical/dental appointments? Yes No

Do you have a referral from a medical provider? Yes No

If YES: Name of clinic _____ Name of provider _____

STATEMENT OF UNDERSTANDING

I understand that this application will be accepted only if the applicant meets the eligibility requirements. I authorize the release of any financial, medical or other information deemed necessary to **Community Health Connect** to determine eligibility. By signing this form, I authorize **CHC** to verify information provided. I certify that the information provided in this application is true and correct to the best of my knowledge.

Signature of Applicant, Parent or Guardian

Date

HEALTH HISTORY FORM

Name: _____

Personal Physician: _____ Date: _____

Date of last physical exam: _____

YOUR MEDICAL HISTORY

Are you in good health? Yes No

Are you currently under medical treatment? Yes No If yes, what for? _____

Are you taking ANY medication? Yes No If yes, what are you taking? _____

Hospitalized or Surgery in the last two years? Yes No If yes, what for? _____

HAVE YOU HAD THE FOLLOWING:

| | | | | | |
|--|---|---|--------------------------------|---|---|
| AIDS..... | Y | N | Claustrophobic | Y | N |
| Arthritis / Rheumatism..... | Y | N | Herpes..... | Y | N |
| Artificial prostheses | Y | N | High Blood Pressure | Y | N |
| <i>Knee, hip, heart valve, etc.</i> | | | HIV Positive..... | Y | N |
| Asthma..... | Y | N | Kidney Problems | Y | N |
| Bleeding Problems..... | Y | N | Oral Birth control | Y | N |
| Cancer..... | Y | N | Osteoporosis | Y | N |
| Diabetes | Y | N | Phen-Fen use | Y | N |
| Emphysema | Y | N | Pregnant..... | Y | N |
| Glaucoma..... | Y | N | Rheumatic Fever..... | Y | N |
| Heart problem | Y | N | Sexually Trans. Diseases | Y | N |
| <i>Heart Attack, Stroke, Pace Maker,</i> | | | Sinusitis | Y | N |
| <i>Damaged Valves, etc.</i> | | | Thyroid Problems..... | Y | N |
| Hepatitis..... | Y | N | Tuberculosis..... | Y | N |
| Smoke or use tobacco | Y | N | Ulcers..... | Y | N |
| | | | Other Diseases..... | | |

ARE YOU ALLERGIC TO OR HAVE DIFFICULTY TAKING THE FOLLOWING:

| | | | |
|----------------------------|---|---|-------------------------------|
| Aspirin..... | Y | N | Other Antibiotics? What |
| Codeine..... | Y | N | _____ |
| Anesthetic (Novocain)..... | Y | N | Other Medications not listed? |
| Penicillin | Y | N | _____ |

Is there ANY medical condition which we need to know about which may influence our treatment?

YOUR DENTAL HISTORY

Date of your last Dental exam: _____

Have you noticed?

| | | |
|--|---|---|
| Teeth tender to chew | Y | N |
| Bleeding gums..... | Y | N |
| Bad Breath | Y | N |
| Spaces developing between teeth..... | Y | N |
| Sensitivity to heat, cold, or sweets | Y | N |
| Any sore areas in your mouth..... | Y | N |
| Pain in or near your ears..... | Y | N |

Have you ever been treated for?

| | | |
|----------------------------|---|---|
| Gum disease..... | Y | N |
| Orthodontics (braces)..... | Y | N |

Have you received instruction in the care of your teeth and gums? Y N

Do you have ANY concerns about dental treatment that will help us make it a more comfortable experience?

For Patients, Parent or Guardian of Patients Under 18 Years of Age: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect treatment, I understand the importance of and agree to notify the health care professional of any changes at any subsequent appointment.

Signature of Patient, Parent or Guardian

Date

CONSENT TO DIAGNOSE AND TREAT

I, (print name) _____ consent to and authorize the health service provider to perform diagnostic procedures that will determine current status and will be used to determine future treatment.

I also consent to and authorize the health service provider to whom CHC has or will refer me to provide treatment.

I understand that after treatment is begun, other procedures may be necessary that were not originally planned.

I acknowledge no guarantees have or will be made to me by either CHC or the health service providers to whom I have been referred by CHC as a result of examination or treatments.

I also consent to and authorize Community Health Connect staff and the staff of the office to whom CHC refers me to handle my medical and/or dental records for the purpose of improving my state of medical and/or dental health.

I understand that the health care professional is providing the services without receiving remuneration or compensation and that in exchange for receiving uncompensated health care, I consent to waive any right to sue for professional negligence except for acts of omissions which are grossly negligent or are willful and wanton.

For Patients, Parent or Guardian of Patients Under 18 Years of Age: This form has been explained to me, and I certify that I understand and consent to its contents and I have received a copy of this form.

Signature of Patient, Parent or Guardian

Date



COMMUNITYHEALTH
CONNECT

AUTHORIZATION FOR RELEASE OF INFORMATION

| PATIENT INFORMATION | | |
|---------------------|-------------|-----------------|
| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: |
| ADDRESS: | CITY/STATE: | ZIP CODE: |

| Description of the Information to be Released |
|--|
| <p>The Patient identified above authorizes the disclosure of all protected medical information in any form (including oral, written and electronic) to Community Health Connect (CHC), and Requestors' re-disclosure of the data and information to its agents, coordinators, physician, hospital, and the entities and organizations specified below. Patient expressly requests that all covered entities under HIPAA shall disclose full and complete protected health information concerning the Patient. This includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • All medical records, including, but not limited to: inpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, examination reports, office and doctor's handwritten notes, and records received from other physicians or health care providers • All laboratory, histology, pathology, CT scan, MRI, echocardiogram reports • All radiology films • All pharmacy prescription records • All insurance or billing information |

| Organization Providing the Information | Organization to receive the information | | |
|--|---|--|---|
| Community Health Connect | <table border="0"> <tr> <td> Dept. of Workforce Services Division of Child and Family Services Division of Services for People with Disabilities Primary Care Network Health Clinics of Utah Central Utah Clinic Mountainlands Community Health Center Primary Care Providers Specialty Physicians Mental Health Providers School Districts </td> <td> Health Clinics of Utah Utah Valley Regional Medical Center Mountainview Hospital Timpanogos Hospital Surgical Centers Case Manager/ Family Advocate State/ Local Health Dept. (Including WIC) Substance Abuse Treatment Providers Caring Foundation for Children Dental Providers Other </td> </tr> </table> | Dept. of Workforce Services Division of Child and Family Services Division of Services for People with Disabilities Primary Care Network Health Clinics of Utah Central Utah Clinic Mountainlands Community Health Center Primary Care Providers Specialty Physicians Mental Health Providers School Districts | Health Clinics of Utah Utah Valley Regional Medical Center Mountainview Hospital Timpanogos Hospital Surgical Centers Case Manager/ Family Advocate State/ Local Health Dept. (Including WIC) Substance Abuse Treatment Providers Caring Foundation for Children Dental Providers Other |
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| Purpose for the Use or Release of the Information |
|--|
| Release of this information is requested for the purposes of obtaining access to health care for those in need and to further the assessment and treatment of the patient. |

This authorization for release of the above information to the above named persons/organizations will expire a year from date signed. I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I understand that this authorization is voluntary.
- I have the right to revoke this authorization by sending a notice stopping this authorization to Community Health Connect at 250 West Center Street # 111, Provo, UT 84601. The authorization will stop on the date my request is received.
- I understand that I am entitled to receive a copy of this authorization.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand that, after information is released under this authorization, it may be re-disclosed by the recipient, and if re-disclosed, the information will no longer be protected by federal or state privacy rules.
- I understand that I retain the right to refuse to sign authorization
- I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization will be that personal information records, billing, or other sensitive information, will not be shared with outside partners, which will make it difficult for Community Health Connect to provide me with further treatment.
- Any facsimile, copy or photocopy of the authorization authorizes the release of all records requested herein.

| | |
|------------|-------|
| Signature: | Date: |
|------------|-------|