COMMUNITYHEALTH
CONNECT

Patient Responsibilities

Community Health Connect (CHC) is a nonprofit health access organization. We have contacted local physicians, dentists, and other specialists who are volunteering their services to help you get well and stay well. We are not an insurance company, nor is this an government or "entitlement" program. Our assistance may be terminated at any time and for any reason. CHC does not cover emergency room, ambulance services, lab/exam fees, or any other separate expenses incurred. Your responsibilities under this program, the services available, and other conditions of the program may change at any time. We reserve the right to require that you pay for any assistance you may have received based on inaccurate information provided by you.

PLEASE INITIAL AT LEFT TO SHOW YOU UNDERSTAND EACH RESPONSIBILITY:

__________ I will NOT schedule appointments with any CHC network provider (doctor, dentist, clinic, or hospital). All appointment will be made by the CHC care coordinator. If one has been made for me I will notify CHC **immediately**. I understand that if I have any questions or concerns with this policy, I may speak to my care coordinator, and they will review it on a case by case basis.

__________ I understand that CHC cannot guarantee free services, but will act as an advocate to reduce all related healthcare costs as much as possible.

__________ I will be responsible for all cost incurred by visits that have not been scheduled by CHC staff.

__________ I understand that if I receive any bills in connection with any services provided from the CHC network, I must bring them in to the CHC office within one week of receipt.

__________ I understand that I must follow the treatment plan provided by CHC service providers.

__________ I will promptly provide any information which may be requested by the program. If I do not provide requested information within 10 days my eligibility will be denied.

__________ I will allow all information regarding my participation in this program to be shared with other individuals, organizations, and agencies solely at the discretion of CHC.

__________ I will apply for Medicaid or other assistance programs at the request of CHC.

__________ I will immediately contact CHC if my income changes or if I become covered by Medicare, Medicaid, private insurance, or other health insurance or medical benefits.

__________ I will contact CHC immediately with any changes in address, phone number or household income.

__________ I understand that the network providers are donating their services and I will behave myself accordingly while in their office, acting professionally and courteously, respecting the provider's time, their office, and their staff. I will turn off my cell phone or pager during the appointment. I understand that the provider's office is not a day care facility and I will not bring unattended children to the office or facility.

__________ If I cannot make arrangements to get to an appointment, I will call CHC staff at least 24 hours prior to that appointment and cancel. In the case of surgery, I will call CHC 72 hours prior to the appointment to cancel.

__________ I understand that I am responsible to arrive at ALL scheduled appointments on time. If I arrive late and the appointment has to be rescheduled, I understand that it will be counted as a missed appointment.

__________ If I miss an appointment, I am aware that I will be required to pay $25 to reinstate my eligibility. If I miss a second appointment I will be dismissed from the program.

__________ I understand that if I miss a scheduled surgery I will be dismissed from the program immediately, without the opportunity for a second chance.

By signing below, I confirm that I understand and agree to the above conditions, and have received a copy of this form. If I do not follow the above guidelines, I may be terminated from CHC.

____ ____________________
Signature of Patient, Parent or Guardian Date

COMMUNITYHEALTH CONNECT

Medical ☐
Dental ☐

Application for Enrollment

DIRECTIONS! Please submit the following with your competed application: 1) 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) $50.00 DENTAL donation.

APPLICANT INFORMATION

Name: Last First Middle	Age:	Date of Birth: (mo/day/yr) / /	Sex: M ☐ F ☐	Social Security No. or ITIN No.:
Address: Street City State Zip	County	Phone Number (include area code)		

HOUSEHOLD INFORMATION

Name of applicant, Parent or Legal Guardians (if applicable): Last First Middle	Current Individual Gross Monthly Income:	Relationship to Applicant:
Employer's Name or date of last employment:	Employer's Address:	Work Number (area code) ( )
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 (area code) ( )
Are you or your spouse receiving: ☐Workers Compensation ☐SSI/SSA ☐Unemployment ☐Disability Amount $ _______________per month/year		Are you receiving child support? ☐Yes ☐No Amount $____________per month/year
Do you or the applicant have dental insurance? ☐ Yes ☐ No If yes, please name insurance company	Do you or the applicant have medical insurance? ☐ Yes ☐No If yes, please name insurance company	Applicant or Responsible Party's Marital Status: ___Single ___Married ___Divorced ___Separated ___Widowed
Are you or your children on CHIP, Medicaid or PCN? If yes, list individuals and type of coverage.	Have you or your children ever applied for CHIP, Medicaid, or PCN? Please explain:	
Number of Children in Household : Number of Adults in Household:	TOTAL GROSS MONTHLY HOUSEHOLD INCOME:	

EMERGENCY/ALTERNATE CONTACT

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

FOR OFFICE USE ONLY

Date Received: _______________ Eligible / Ineligible Poverty Level ___________ Date photo was taken: __________
CHC ID #____________________ Intake person: _________________ App. -☐ Med-Den history -☐ Patient Res. -☐
Reviewed by: ___________________ Consent-☐ HIPPA -☐

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 have a referral from a medical provider? Yes ☐ No ☐

Do you need an interpreter for your medical/dental appointments? 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
Knee, hip, heart valve, etc.			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
Heart Attack, Stroke, Pace Maker,			Sinusitis	Y	N
Damaged Valves, etc.			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

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:

- 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 form 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	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_________________________

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: