



COMMUNITYHEALTH  
CONNECT

# Application for Enrollment

**For Office Use Only**

Medical \_\_\_\_\_

Dental \_\_\_\_\_

Date of application \_\_\_\_\_

**Please submit the following with your completed application:**

- 1) **Proof of Income** (copy of most recent IRS taxes, W-2, or two most recent earning statements, check stubs)
- 2) **Proof of residence** in Utah County (lease agreement, utility bill, etc.)
- 3) **Referral from a primary care physician** for medical cases indicating medical need.
- 4) \$20 membership fee (eligibility extends 6 months. Membership renewable with updated proof of income and membership fee)

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M  F

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ For how long? \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Marital Status: Single  Married  Divorced  Separated  Widowed  Name of spouse: \_\_\_\_\_

Patient's Employment Status: Working Full-time  Part-time  Laid off  Unemployed  Retired  Disabled  Student

Patient's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Household Monthly Income

Number of individuals living in the home: Adults \_\_\_\_\_ Children \_\_\_\_\_

Type of income:	Amount received per month:
Responsible Party Employment Income (gross)	\$ _____
Spouse Employment Income (gross)	\$ _____
Other household members Employment income (gross)	\$ _____
Workers Compensation, SSI, SSA, Unemployment, Disability, Insurance income	\$ _____
Child Support, alimony, etc.	\$ _____
Received room, board, utilities paid by family, friends, church, etc.	\$ _____
Other: food stamps, WIC, etc.	\$ _____
<b>TOTAL INCOME FOR ALL INDIVIDUALS IN THE HOME:</b>	<b>\$ _____</b>

**Does the applicant have dental insurance?**

Yes  No  If yes, please name insurance company \_\_\_\_\_

**Does the applicant have medical insurance?**

Yes  No  If yes, please name insurance company \_\_\_\_\_

**Do you or your children have CHIP, Medicaid or PCN?** Yes  No

If yes, list individuals and type of coverage on back \_\_\_\_\_

**Have you ever applied for Medicaid or Medicare?**

Yes  No  If yes, when? \_\_\_\_\_

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**Demographic Information (optional)**

**How did the applicant hear about Community Health Connect?**

- Volunteer Care Clinic     Mountainlands     School Nurse     Health Clinics of Utah     Health Department  
 Gappmeyer Clinic     Dixon Clinic     Dr. or Dentist name: \_\_\_\_\_  Other: \_\_\_\_\_

**Ethnicity:**

- African-American     Asian     Caucasian     Hispanic     American Indian     Pacific Islander  
 Other (please specify) \_\_\_\_\_

**Religious Affiliation (check one):**

- Catholic     Eastern Religion     Jewish     LDS     Protestant     Other

**Level of Education:**

- Elementary School     High School     College     Other

**Patient's Citizenship Status:**

- US Citizen     Legal US Resident     Other
- 

**What are the specific Medical or Dental symptoms for which you are seeking treatment through Community Health Connect?**

\_\_\_\_\_  
\_\_\_\_\_

Have you had diagnostic services for this particular need? (X-Rays, lab work, etc.)    Yes     No

If yes, Name of Doctor/Clinic: \_\_\_\_\_ Date of Services: \_\_\_\_\_

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

If yes, Name of Doctor/Clinic: \_\_\_\_\_

Do you need an interpreter for your medical/dental appointments?    Yes     No     If yes, what language: \_\_\_\_\_

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**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 Legal Guardian*

\_\_\_\_\_  
*(Relationship to patient)*

\_\_\_\_\_  
*Date*



## Agreement and Terms of Accepting Treatment

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By signing below, I (print name) \_\_\_\_\_ agree that in exchange for receiving uncompensated health care services, I waive my right to sue or otherwise seek a monetary recovery from Community Health Connect, its employees, and health care professional volunteers for professional negligence except for acts or omissions that are grossly negligent or are willful and wanton, regardless of where such services are performed.

I have been provided the opportunity to ask questions or request further information from Community Health Connect regarding this statement and I understand fully the rights I am giving up.

I understand that this waiver has been made for the purpose of complying with Utah Code Annotated § 58-13-3 that permits me to waive my rights in exchange for receiving uncompensated health care services.

I acknowledge that I have seen, read, and understand the Notice of Limitation of Liability that applies to Community Health Connect and its employees and health care professional volunteers.

I acknowledge no guarantees to service 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 and that enrollment in the program may be terminated at any time.

**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 its contents and agree to the terms as stated above.

\_\_\_\_\_  
*Signature of Applicant, Parent or Guardian*

\_\_\_\_\_  
*Date*



### Authorization for Release of Information

#### PATIENT INFORMATION

<i>LAST NAME:</i>	<i>FIRST NAME:</i>	<i>MIDDLE INITIAL:</i>
<i>ADDRESS:</i>	<i>CITY/STATE:</i>	<i>ZIP CODE:</i>

#### 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 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	Caring Foundation for Children Case Manager/ Family Advocate Central Utah Clinic Dental Providers Dept. of Workforce Services Division of Child and Family Services Division of Services for People with Disabilities Health Clinics of Utah Mental Health Providers Mountainlands Community Health Center Mountainview Hospital Primary Care Network Primary Care Providers School Districts Specialty Physicians State/ Local Health Dept. (Including WIC) Substance Abuse Treatment Providers Surgical Centers Timpanogos Hospital Utah Valley Regional Medical Center Volunteer Care Clinic 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 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 591 South State Hwy, Provo, UT 84606. 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 of patient, parent or guardian*

\_\_\_\_\_  
*Relationship to patient*

\_\_\_\_\_  
*Date*



## 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 a government or “entitlement” program. We work as patients advocates to coordinate care provided by these volunteers throughout the community. CHC does not pay for any services. Ultimately you are responsible for your care. Our assistance may be terminated at any time and for any reason.

**PLEASE INITIAL EACH SPACE ON THE LEFT TO SHOW YOU UNDERSTAND EACH RESPONSIBILITY:**

- \_\_\_\_\_ I understand that CHC coordinates donated and discounted services, but that there will sometimes be additional associated bills due to lab, facility, anesthesiology, and other diagnostic services and fees, and that I am responsible for paying for these services. I understand that CHC will act as an advocate to reduce **all related health costs** as much as possible but that ultimately my health, healthcare, and the associated bills are **my** responsibility.
- \_\_\_\_\_ I will NOT schedule appointments with any CHC network provider (doctor, dentist, clinic, or hospital). All appointments will be made by the CHC care coordinator. If the provider schedules a follow-up visit, 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 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 form the CHC network, I must bring them in to the CHC office within **one week** of receipt if I want the assistance of a care coordinator in advocating for a discount or setting up a payment plan.
- \_\_\_\_\_ I understand that I must follow the treatment plan provided by CHC service providers, and if I choose not to follow this plan, I will not be sent to an alternate provider, but will be dismissed from the program. CHC does not send patients for a “second opinion”.
- \_\_\_\_\_ I will promptly provide any health, financial, or personal 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 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 appropriately while in their office, acting professionally and courteously, respecting the provider’s time, their office, and their staff. I will show appreciation for the provider’s services.
- \_\_\_\_\_ I will turn **off** my cell phone 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 48 hours prior to that appointment cancel or reschedule. If I cannot get a hold of CHC staff I will call the doctor’s office directly. In the case of surgery, I will call CHC 72 hours prior to the appointment to cancel.
- \_\_\_\_\_ If I miss any appointment I will be dismissed from all CHC programs. I am aware that I will be able to plead my case to CHC management, and if they reinstate my eligibility I will be required to pay a 25\$ fine.
- \_\_\_\_\_ 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 (see above)
- \_\_\_\_\_ I understand that if I miss a scheduled surgery I will be dismissed from the program immediately.

**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*