Dear HealthAccess Patient:

Please use this re-application form if you have been enrolled in HealthAccess during the last year and would like to re-apply. You must complete all of the requested information and forms to be considered for re-enrollment. Please read carefully and follow the instructions. If you have questions about any of the requested information you may call the HealthAccess office at 235-0996.

Please mail all requested information to:

SCMS HealthAccess
PO Box 615
Topeka, KS 66601-0615

The HealthAccess office cannot make copies for clients and is not staffed to accept hand delivered materials.

Re-application does not guarantee that you will continue to qualify for the program. If you do not qualify you will receive a letter notifying you of the reason's why.

Please keep track of when your cards expire and remember that they will not be active beyond that date. Your cards will be active when you receive them in the mail.

Please remember to thank the doctors and nurses that have been caring for you. They are volunteering and donating their services to help you get well and stay well.

Thank You,
SCMS HealthAccess

HealthAccess Re-enrollment Form

Name:
Address:
ID #: RX ID #:
HealthAccess card effective dates:

(It may take 3-4 weeks after these forms are received to complete your re-enrollment.)

Is your mailing address different than that given above? ☐No ☐Yes (If yes, please list mailing address.)
____

What is your home telephone number? ___________________

What is your work telephone number? ___________________

Do you have Medicare, Medicaid, HealthWave, or any other type of state/federal medical benefit or private health insurance? No ____ Yes ____ (If yes, please explain.)
____

How many individuals currently live in your household? _______ Beginning with yourself, please list all below including their relationship to you. If they are new to your household since you last enrolled, please indicate when they entered your household.

Name	Date of Birth	Relationship
____________________________	____________	__Self__________________
____________________________	____________	________________________
____________________________	____________	________________________
____________________________	____________	________________________
____________________________	____________	________________________
____________________________	______ ____	________________________
____________________________	___________	________________________
____________________________	___________	________________________

Have you gone to the Emergency Room in need of care since you have been enrolled in HealthAccess? ☐Yes ☐ No If yes, when: ______________ Please explain why:

Has the source of your income changed? ☐No ☐Yes (If yes, please tell us how.) ____________
____

In the blanks below, please list all sources of income for the past 4 weeks for household:			
	Name	Amount	How Often
Paycheck			
Paycheck			
Tips			
TAF			
Child Support			
Alimony			
Unemployment			
Worker's Compensation			
Pension			
Social Security			
SRS/Cash Assistance			
Other Income			

What is your total monthly gross income: $________ (**Please attach proof of your income and proof of income for your spouse or parent of your children if they reside with you**.)

If you receive Social Security benefits, when will you be eligible for Medicare? _________
Please attach proof from Social Security.

____ __________
Applicant Signature (or signature of Mother or Father of applicant if minor is under 18) **Date**

1. Please collect your most recent check stubs (4 weeks) and make copies of them to return to HealthAccess. If you do not have check stubs, please provide written verification of the last four weeks gross income from the source of this income. If there is no income for the household, please provide a written statement(s) from the people who are supporting you, this must be signed and dated by them.

2. Please read, sign, and return the enclosed Patient Responsibilities form and Consent form, along with the income verification. The Patient Responsibilities form will be sent back to you with your updated ID cards if you still qualify, or you will receive a letter explaining why you are no longer eligible.

3. Please mail this form, proof of income, signed consent form, and signed patient responsibilities to:

SCMS HealthAccess
PO Box 615
Topeka, KS 66601-0615

Note: The HealthAccess office cannot make copies and is not staffed to accept hand delivered materials.

PATIENT RESPONSIBILITIES FORM

Program overview

Doctors, area clinics, pharmacists, hospitals and many others are donating their services to help you get well and stay well. They are not being paid for the services provided to you. This is not a government program, nor an entitlement program. The donated care may end at any time, for any reason. HealthAccess does not include emergency room expenses or ambulance services. By signing this form you authorize HealthAccess to verify what you have reported during the application process, if you have provided false information that makes you ineligible for HealthAccess, you may be financially responsible for the donated care you received. You may also receive some bills, for which you are responsible, should you need services not currently being donated for the HealthAccess program.

General

You agree that you:

1. Will not schedule appointments with any doctor, clinic or hospital other than the ones to which you have been referred.
2. Will follow your treatment plan, for example: get prescribed medicines and take as directed.
3. Will promptly supply any information which may be requested by the program within the time frame requested.
4. Will allow all information regarding your participation in this program to be shared with other individuals, organizations and agencies at the discretion of SCMS HealthAccess in accordance with state and federal laws.
5. Will immediately contact your enrollment site or SCMS HealthAccess if your income changes or you become covered by Medicare, Medicaid, private insurance, other health insurance or medical benefits.
6. Will apply for Medicaid, Healthwave or other assistance programs if and when you are eligible.
7. Will authorize the State Department of Social and Rehabilitation Services to share information regarding your eligibility for Medicaid and other SRS programs with SCMS HealthAccess staff and with SCMS HealthAccess medical providers.
8. Will contact SCMS HealthAccess immediately with any changes in address or phone number.

By signing this form you confirm that you understand and agree to the above conditions and that the income information you provided is accurate. If you do not follow the above guidelines, you will be disenrolled from SCMS HealthAccess.

Applicant Signature (or Signature of Mother or Father of Applicant if Minor is under 18):

Referrals

You agree to:

1. Keep each doctor's appointment. (if you miss 3 or more appointments in 12 months without letting the doctor's office know at least 24 hours before your appointment, you will be disenrolled from the program.)
2. If you are unable to keep an appointment, **you** are responsible for notifying the doctor's office with whom you are scheduled, at least **24 hours in advance** to cancel and reschedule the appointment.
3. Present your SCMS HealthAccess Patient I.D. card each time you see a doctor.
4. Call your enrollment site or SCMS HealthAccess doctor if you need to be seen anywhere else for care.

Medications Assistance

You understand that:

1. There is a 12 month maximum coverage of $750, and a maximum cost of $200 per prescription, unless funds are available and preauthorized by SCMS HealthAccess.
2. Most Generic medications are available through this program. Your physician may be contacted and asked to use medications which are covered by the program.
3. A pharmacy may stop participating at any time, for any reason.
4. A co-pay per prescription will be required by your pharmacy.
5. You are to present your medication card each time you have a prescription filled.

Please Note

- HealthAccess will not discriminate based on race, religion, color, sex, disability, age, national origin or ancestry, or in any other manner as described in state and federal guidelines.
- HealthAccess does not provide medical care or services and does not make decisions regarding medical treatment plans. Those decisions remain between the providers and patients.
- All voluntary providers are independent contractors; they are not considered agents or employees of HealthAccess.
- HealthAccess is not responsible for bodily injury or negative outcomes potentially experienced within the provision of services by voluntary care providers. HealthAccess cannot guarantee the skill, care or training of voluntary providers

Authorization Allowing Disclosure of Protected Health Information

I hereby authorize all health care providers providing services or treatment to me through the Shawnee County Medical Society Foundation Inc.'s HealthAccess Program to disclose information regarding all medical treatment regardless of format, *e.g.*, written, verbal, or electronic in the possession of such health care provider (hereinafter "office/hospital") to Shawnee County Medical Society and Shawnee County Medical Society Foundation, Inc., and to their agents, representatives, and employees, including, but not limited to, Blue Cross and Blue Shield of Kansas, Inc., the Kansas Department of Social and Rehabilitation Services, and their agents, representatives, and employees to manage, operate, and evaluate the HealthAccess Program.

The Authorization will expire on my disenrollment from the HealthAccess Program.

I understand I have the right to revoke the Authorization by delivering such revocation in writing to the office/hospital. I understand Shawnee County Medical Society Foundation, Inc. may terminate my participation in the HealthAccess Program if I revoke this Authorization.

Once the uses and disclosures have been made pursuant to this Authorization, they may be subject to redisclosure by any recipient and no longer protected by the federal privacy laws.

Office/Hospital will not condition treatment on my providing authorization for this use or disclosure. I understand, however, that the HealthAccess Program requires this signed Authorization prior to my being allowed to participate in the HealthAccess Program.

I understand that I may inspect or copy the protected health information to be used or disclosed under this Authorization. I understand I may refuse to sign the Authorization but that if I refuse to sign this Authorization, I may not be allowed to participate in the HealthAccess Program.

I understand that I will receive a copy of this Authorization.

____

Applicant Signature (if Patient is a Minor Under 18 years, the Name of the Minor is Necessary)

____

Applicant Signature (or Signature of Mother or Father or Personal Representative of Applicant if Minor is Under 18)

____

Description of Representatives Authority to Act for Patient

Date: ____________________