Phoenixville Health Care Access Program
723 Wheatland Street, Suite 2C, P. O. Box 591, Phoenixville PA 19460

HEALTH CARE ACCESS PROGRAM APPLICATION

Date of Application:_______ Vision____Dental___Ortho____Rx_____

1. Name_________________________ Date of Birth__________ SS#_______________
   Name_________________________ Date of Birth__________ SS#_______________
   Name_________________________ Date of Birth__________ SS#_______________
   Name_________________________ Date of Birth__________ SS#_______________
   # in Household_____________ #Adults_______ #Children________

2. Provide copy of Driver's license, birth certificate or another form of identification with this application. Race (optional)__________________

3. Address and phone numbers

____

______________________Township_________________________

Home Phone_________________________ Work Phone__________________________

4. Marital status: single married divorced (circle one)

5. Employment status: yes or no Spouse yes or no Welfare: yes or no

6. Household combined income: _________________ Mthly or Wkly (circle one) **All parties who contribute to household income count toward income verification.

7. Name, address, and phone number of Employer(s):

Applicant	Spouse
_______________________________	_________________________________
_______________________________	_________________________________
Wk. Phone: ____________________	Wk. Phone: ______________________

8. Income verification: Must submit pay stubs or employer verification of current income or income tax return. Photocopies will be maintained in patient record.

9. Do you have dental/vision/orthopaedic/prescription insurance or are you eligible for any other state or private programs? yes or no
Medical Health Ins? yes or no
Name of insurance co.____

10. Have you applied to other programs for dental/vision/orthopaedic/ prescription assistance? yes or no
If yes, please identify program and reason given for ineligibility.

____

11. Please provide a brief summary as to the nature of your dental/vision/ orthopaedic/medication needs.

____

12. When was your last dental/vision visit? ____________________________________

13. Also, how did you learn about this program?
____

HEALTH CARE ACCESS PROGRAM
APPLICATION- Pg. 2

14. I understand and agree to the following Health Care Access Programs No Show Policy: If I'm unable to keep a scheduled appointment at the provider's office, I agree to call the provider office 24 hours in advance. If I fail to contact the office, I will be responsible for a $35.00 No Show fee per missed appointment payable to the provider prior to any future appointments. If I have more than one no show, I may be discharged from the Health Care Access Programs.

15. I acknowledge that all of the information provided is true. I acknowledge that no other adult contributes to the income of the household. I understand that this application is for immediate care or emergency care and does not constitute ongoing financial support or care on part of the program or the doctor. The final approval is subject to a provider treatment request, available program funds, and program approval. (Approval is based upon the provider's exam and program application verification and available funding. The Health Care Access Program does not guarantee approval for dental/vision/orthopaedic/prescription services.)

16. I agree to pay an administrative fee based upon my family income and Program financial guidelines. This fee will be agreed upon by the Program Administrator and myself and paid prior to any dental/vision/orthopaedic visits. These fees are paid directly to the provider.

17. I hereby authorize the release of any information regarding my medical condition and financial need by the Health Care Access Programs, its employees, affiliates and agents for the purpose of rendering services to myself or____________________________, for whom I am making such authorization. I also acknowledge that the information provided to Health Care Access is true and correct to the best of my knowledge.

_______________________________ _________________________________

Applicant's Signature Date Program Admin. Date

PROGRAM USE:

Based upon initial application information and verification the patient application is Approved or Denied: Circle one Vision Dental Orthopeadic Rx
If denied reason why:
____

Return completed application (3 pages) to:

Health Care Access Program
723 Wheatland Street, Suite 2C

Phoenixville Health Care Access Program
723 Wheatland Street, Suite 2C, P. O. Box 591, Phoenixville PA 19460

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HEALTH CARE ACCESS PROGRAM
PATIENT DISCLAIMER

In applying for funds under the Health Care Access Programs, I understand that all diagnosis of treatment and services rendered are the sole responsibility of the provider and his/her practice. I acknowledge that the program is designed to assist me by providing funding for said services subject to program approval.

I understand that this program does not provide for ongoing services beyond what is approved at the time of my application. In the event that I need financial assistance for dental/vision/emergency orthopaedic/prescription services in the future, I must reapply to the program. Previous approval does not assure or guarantee a future approval of a new application. I agree to pay any required administrative co-payments established prior to my approval. All co-pays are to be submitted to the provider prior to my approved visits.

I understand that the goal of the Health Care Access Programs is to enhance access to dental/vision/emergency orthopaedic care and prescription medications for Phoenixville area residents. This goal does not guarantee access or ongoing access to the provider of my choice nor the right to see the same program provider if I receive a future application approval. Of course a patient may continue as a private patient with any practitioner as mutually agreed upon by both provider and family.

The provider who renders treatment to me should not charge me a fee for any services approved by the program. I may agree to additional services for a fee established by the provider. I reserve the right to become a private patient in the practice depending upon the provider's availability.

At no time does the Health Care Access Programs guarantee acceptance or approval of an application.

______________________________ ______________________________

Applicant's Signature Date Program Admin. Date