Health Care Access
710 Wheatland St., Suite 107, P.O. Box 591, Phoenixville PA 19460 610-935-3165
PROGRAM APPLICATION

Date of Application: _____ Vision ☐ Dental ☐ Ortho ☐ Rx ☐ Immigration☐

1. Names of those making application that need help:
Name_____ Date of Birth_____ SS#_____ M☐ F☐ Other ☐
Name_____ Date of Birth_____ SS#_____ M☐ F☐ Other ☐
Name_____ Date of Birth_____ SS#_____ M☐ F☐ Other ☐
Name_____ Date of Birth_____ SS#_____ M☐ F☐ Other ☐
Name_____ Date of Birth_____ SS#_____ M☐ F☐ Other ☐

Number of Household Members _____ #Adults_____ #Children_____

2. **Address** where you live: Street_____Apt._____
City_____Zip_____
Township_____ Home/Cell Phone_____ E-Mail_____

3. Proof of Residency copy attached: Driver's license ☐ ID☐ Copy of Lease☐ Other☐

4. Race (optional) White☐ Hispanic/Latino☐ Black☐ Asian☐ Multiracial☐ Native American☐
Hawaiian/Pacific Island☐ Other☐_____

5. Relationship Status (check one): Single☐ Married☐ Divorced☐ Widowed☐ Cohabitating☐

6. Are you Employed? Yes☐ No☐ Full Time☐ Part-time☐ Retired☐ Disabled☐
Spouse/Partner employed? Yes☐ No☐

7. Household Combined Income: _____ (check one) Monthly☐ Weekly☐ Annual☐
**All parties who contribute to household income count toward income verification.

8. Must submit Income Verification, Copies attached, check all that apply: Pay stubs one month☐
Employer Letter☐ Pension☐ Income Tax Return☐ Social Security Statement☐

9. Do you have any Insurance? Yes☐ No☐ If Yes, what kind? Medicare☐ Medicaid (Access)☐
Insurance from employment☐ Other☐ Name of insurance co._____

10. Have you applied to other programs for dental/vision/orthopedic/prescription assistance?
Yes☐ No☐ If yes, outcome?_____

11. Please provide a brief summary as to the nature of your dental/vision/orthopedic/medication needs. _____
12. Also, how did you learn about this program? _____

Are you currently receiving services or have you received services from CHDC
(Community Health & Dental Care) in Pottstown? Yes☐ No☐ If so, when?_____

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13. I understand and agree to the following Health Care Access Program (HCA) **Zero Tolerance No Show Policy**: If I'm unable to keep a scheduled appointment at the provider's office, I agree to call the provider office **48 hours in advance**. Failure to do so will be considered a **No Show**. Cancelling the same day is a **No Show**. If I fail to contact the office, I will be responsible for a **$50.00 No Show fee that must be paid to the provider prior to scheduling any further appointments. If I have a second No Show, in addition to paying the $50.00 No Show fee to the provider, I will have to wait 6 months to reapply to HCA for assistance**. **A third No Show and I will no longer be eligible for the Health Care Access Programs**. Any exceptions/emergencies will need to be discussed with HCA staff.
No Show Policy acknowledgement: _____
Applicant's Signature Date

14. 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/orthopedic/prescription services/immigration.)

15. 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/orthopedic visits. These fees are paid directly to the provider.

16. 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 Staff Date

PROGRAM USE:

Based upon initial application information and verification the patient application is
Approved or Denied (Circle one): Vision Dental Orthopedic Rx Immigration
If denied reason why:

_____

Return completed application to:

Health Care Access
723 Wheatland Street, Suite 2C
P. O. Box 591, Phoenixville, PA 19460 FAX 610-917-2483

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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 the 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 service 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

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CLIENT GRIEVANCE POLICY AND PROCEDURES

It is the policy of Health Care Access Program that services will be provided to all individuals who are eligible without discrimination on the basis of HIV infection, race, creed, color, age, sex, gender, sexual orientation, religion, ancestry, national origin, physical or mental handicap (including substance abuse), immigrant status, political affiliation or belief.

It is the policy of Health Care Access Program to provide all clients and those seeking services with a copy of the Client Grievance Policy and Procedures and an opportunity to file a grievance. If you choose to file a grievance, you are assured that no adverse repercussions will occur to you in any future interaction with Health Care Access Program. A grievance may be filed for the following reasons:

1. You feel that you were improperly denied services.

2. You feel that the services were not effective.

If you have a grievance or recommendation, you should first discuss it with the Program staff person you are working with. If this is not successful or if you feel this is not an option, you should proceed with the following steps:

1. A written statement should be prepared (including date and time of grievance). You may ask for assistance from any staff. Use the Grievance Reporting form available from Executive Director.

2. Submit the grievance to the Program Director within 5 working days. An appointment will be scheduled for you to meet with the Executive Director to resolve your grievance.

3. If a resolution has not occurred within 10 working days, your grievance will be referred to the Board Chair.

4. If the determination of the Board Chair is still not satisfactory to you, it may be requested that the Health Care Access Board of Directors review the matter at their discretion, and their decision will be final.

I have received a copy of this Grievance Policy & Procedure.

_____ _____

Signature Date

5/9/07
Revised September 12, 2018