Health Care Access
723 Wheatland St., Suite 2C, 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 ☐
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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

Revised September 2017