

PLEASE COMPLETE AND RETURN



Voluntary Care Network Application

Name of Client _____
(Last) (First) (Middle Initial)

Street Address _____ **Telephone (home)** _____

City _____ **State** ____ **Zip** _____ **Telephone (alternate)** _____

Date of Birth _____ **Social Security** _ _ - - - - - **Sex** __Male __Female

Emergency Contact _____
(Name) (Relationship) (Phone)

Case Manager (if applicable) _____
(Name) (Phone)

Legal Marital Status: ___Married ___Divorced ___Single ___Widowed

If married, does your spouse live in the home with you? ___yes ___no

Employed? ___yes ___no **Employer** _____

Race

- | | |
|---|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Guamanian / Chamorro |
| <input type="checkbox"/> African-American (Black) | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> African-Somalian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> American Indian /Alaska Native | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Russian/ former Soviet Union |
| <input type="checkbox"/> Caucasian (White) | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese |
| | <input type="checkbox"/> Other _____ |

When visiting a physician, do you need help speaking and understanding English? yes no

Is English your first language? yes no **If no, please tell us what your first language is** _____

-OVER-

Please answer all questions by placing an [x] in one box next to the correct answer. Questions not answered may delay your application review process.

1. Do you currently have any health insurance? yes no
If yes, please indicate which one:
 Medicaid Medicare VA Benefits Private Health Insurance
2. Are you an active duty veteran? yes no
3. Do you have a work related injury or do you have an open workers compensation case? yes no
If yes, what is the injury? _____
4. Do you have any legal action anticipated regarding any injury or illness? yes no
5. Are you the legal guardian or parent of any children under the age of 18 living in the home with you? yes no
If yes, how many? ____
6. If you are a female, are you pregnant? yes no
7. Are you having problems with your vision? yes no
8. If you have diabetes or high blood pressure, was your last eye exam over a year ago? yes no
9. What is your monthly gross household income? \$_____/month

Household includes you, your spouse, and children only. Income includes any earned or unearned money from each person in your household from any source, such as wages, self-employment, social security(SSDI), supplemental security income(SSI), food stamps, VA pension, workers compensation, alimony or child support. Use chart below to see if you meet the income guidelines.

**** If you have previously applied for Medicaid, VA Benefits, or Medicare and were denied, please send a copy of the denial letter with this application.**

INCOME CHART

Household Size	1	2	3	4	5	6	7	8	For each additional family client add:
Monthly Income	\$1,701	\$2,281	\$2,861	\$3,441	\$4,021	\$4,601	\$5,181	\$5,761	\$290
Yearly Income	\$20,420	\$27,380	\$34,340	\$41,300	\$48,260	\$55,220	\$62,180	\$69,140	\$3,480

Example: If you have a household size of 4 and your monthly gross household income is equal to or less than \$3,225, then you meet the income requirement for the program.

10. In the past 12 months, how many times have you been a patient in a Hospital Emergency Room? _____
11. In the past 12 months, have you had one person or place you think of as your personal doctor or health care provider?
yes no if yes, where _____
12. In the past 12 months, how easy/hard was it to get the health care you needed?
Very hard Somewhat hard Somewhat easy Very easy Did not need care in the past 12 months
13. Overall, how would you rate your health during the **past 4 weeks?**
Excellent Very Good Good Fair Poor Very Poor

→→→→ CONTINUE TO NEXT PAGE →→→→

14. During the **past 4 weeks**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?
- Not at all Very little Somewhat Quite a lot Could not do physical activities
15. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your health?
- None at all A little bit Some Quite a lot Could not do daily work
16. How much **bodily** pain have you had during the **past 4 weeks**?
- None Very mild Mild Moderate Severe Very Severe
17. During the **past 4 weeks**, how much energy did you have?
- Very Much Quite a lot Some A little None
18. During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?
- Not at all Very little Somewhat Quite a lot Could not do social activities
19. During the **past 4 weeks**, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?
- Not at all Slightly Moderately Quite a lot Extremely
20. During **the past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?
- Not at all Very little Somewhat Quite a lot Could not do daily activities
21. Compared to one year ago, how would you rate your health in general now?
- Much better than one year ago
 - Somewhat better now than a year ago
 - About the same as a year ago
 - Somewhat worse now than a year ago
 - Much worse now than a year ago

22. Where did you hear about Access HealthColumbus? _____

Print Name _____ **Client Signature** _____ **Date** _____

******YOUR APPLICATION IS NOT COMPLETED******

Please flip this application over (pg. 4) to READ and SIGN the “Client Agreement.” Failure to sign the Client Agreement may delay your application review process.

-OVER-

Rev 09/07

Client Agreement

Program Overview

Access HealthColumbus (AHC) doctors, area clinics, pharmacists, hospitals and many others are providing their services to help you get well and stay well. Through the Access Network Program, AHC will help you to set up a medical home. A medical home is a place for you to receive continuous medical care. Most services are at no cost to you and some services will be provided based on your income.

General

You agree that you will:

1. Inform AHC of appointments with any doctor, clinic, or hospital other than the appointments scheduled by AHC.
2. Follow your treatment plan, for example: get prescribed medicines and take them as directed.
3. Promptly supply any information, which may be requested by AHC.
4. Subject to situations where a specific authorization is required by law, relevant information regarding your participation in this Program may be shared with other individuals, organizations and agencies solely at the discretion of AHC.
5. Immediately contact AHC if your income changes or if you become covered by Medicare, Medicaid, private insurance, or other health insurance or medical benefits.
6. Apply for Medicaid or other assistance programs at our request.
7. Contact AHC immediately with any changes in your address or phone number.
8. All children under 18 years of age must be accompanied by a parent or guardian to all appointments.

Appointments

You agree to:

1. Keep each physician's appointment. (If you miss two appointments without letting AHC know at least 24 hours before your appointment, you can be dropped from the Program).
2. Fill out all forms given to you during your medical appointment.
3. Fill out Hospital Care Assurance Program forms if you need to go to the hospital for any services.
4. Present your AHC ID card each time you see a physician or healthcare provider.
5. Call AHC to schedule your medical appointments.
6. Call AHC if a physician or healthcare provider schedules any follow up appointments for you.

Billing Assistance

You understand that:

- It is very important to immediately send any bills you receive to the Access HealthColumbus so that we may be able to resolve them as quickly as possible.
- It is important that you fill out a Hospital Care Assurance Program form when receiving services from the hospital and cooperate in providing all necessary information required in completing those forms and updating information on these forms as needed.

Medication Assistance

You understand that:

- It is very important you receive and take your medications as prescribed.
- AHC will assist you in obtaining your medications for a nominal co-payment per monthly prescription **for approved medications only.**

Transportation Assistance

- AHC will assist you in providing transportation services when needed.
- Transportation services are to be used for AHC related appointments only.
- Abuse of transportation services may result in loss of transportation privileges.

In order to enable AHC to create a suitable environment for you to receive quality care, there are some guidelines which must be followed: **Emergency rooms not covered.** Access HealthColumbus does not cover emergency room expenses, ambulance or medical supply services. Please note that this Program is not a government program or an "entitlement." This Program, and your participation in it, is subject to termination at any time and for any reason. Your responsibilities to this Program, the assistance available and other conditions of the program may change at any time. We reserve the right to check what you have told us and to require that you pay for any assistance you may have received based on inaccurate information provided by you. AHC reserves the right to modify or terminate this agreement at any time.

By signing below, you confirm that you understand and agree to the above conditions.

Client Signature _____

Date _____

If you have questions call:

Access HealthColumbus at 614-884-2441

Rev 09/07

Please return completed application to Access HealthColumbus, 61 Jefferson Ave., Columbus, Oh 43215



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2. Follow your treatment plan, for example: get prescribed medicines and take them as directed.
3. Promptly supply any information, which may be requested by AHC.
4. Subject to situations where a specific authorization is required by law, relevant information regarding your participation in this Program may be shared with other individuals, organizations and agencies solely at the discretion of AHC.
5. Immediately contact AHC if your income changes or if you become covered by Medicare, Medicaid, private insurance, or other health insurance or medical benefits.
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If you have questions call:

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ACCESS HEALTHCOLUMBUS
NOTICE OF PRIVACY PRACTICES

**If you have any questions about this notice, you may contact the Privacy Official
at (614)-884-2441.**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice will tell you about the ways in which Access HealthColumbus, Inc. (“AHC”) may use and disclose medical information about you. It also describes your rights and certain obligations that we have regarding the use and disclosure of your medical information.

AHC is required by law to maintain the privacy of your health information, give you notice of our privacy practices with respect to your medical information, and follow the terms of this Notice. This Notice applies to all of the records of your care generated and maintained by AHC. AHC will share your medical information as necessary internally in order to carry out your treatment, obtain or provide payment for the services provided to you or operate AHC.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that AHC may use and disclose your medical information. These are examples and, therefore, not every permitted use and disclosure is listed.

For Treatment. AHC may use medical information about you to enroll you in AHC’s Network so that medical treatment or services may be provided to you. We may disclose medical information about you to doctors, nurses, technicians, medical students and other trainees, or other AHC personnel who are involved in taking care of you. Different AHC personnel may share medical information about you in order to schedule appointments and coordinate the different services you need, such as prescriptions, lab work and x-rays. We may also disclose medical information about you to people outside AHC who may be involved in your medical care, such as physicians involved in your care, or other health care related entities such as hospitals or skilled nursing care facilities with whom you seek treatment.

For Payment. AHC may use and disclose medical information about you so that the treatment and services you receive may be paid by AHC, when applicable. For example, we may disclose your medical information to other health care providers, such as pharmacies, so that they can bill AHC for the health care services that they provided to you.

For Health Care Operations. AHC may use and disclose medical information about you for its operations. These uses and disclosures are necessary to run AHC and make sure that individuals enrolled in AHC’s Network receive quality health care. For example, we may use medical information to review the treatment and services provided to you and to evaluate the performance of physicians participating in the Network that care for you. We may also disclose medical information to doctors, nurses, technicians, medical and nursing students, and other AHC personnel for review and learning purposes. We may also provide medical information to other health care providers who have a relationship with you and need the information for their own health care operations.

Appointment Reminders. We may use and disclose your medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved With or Concerned About Your Care. Unless you object, we may release information about your condition to a friend or family client relevant to his/her involvement in your care or payment for your care. There may also be instances where, because you are either not present or lack the capacity to object, we may release information about your condition to a friend or family client if we determine, based upon our professional judgment, that the release of information is in your best interests. We may also disclose your location and condition to assist or notify a family client or personal representative who is involved in your care. We may also disclose your information in a disaster relief effort so that your family can be notified about your condition and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. Often, you will need to give permission before we share your information with others for use in research. If your information is used, the researcher must keep your information safe and confidential. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with individuals' need for privacy of their medical information.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, Ohio law requires us to report gunshot and stabbed wounds as well as certain burn injuries.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation. We may release medical information about you for worker's compensation or similar programs which provide benefits for work-related injuries or illness.

Public Health Activities. We may disclose medical information about you for public health activities such as the prevention or control of disease, injury or disability; reporting of births and deaths; reporting of child abuse or neglect; and, reporting of reactions to medications or problems with products and to fulfill requirements of the U.S. Food and Drug Administration.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities allowed by law such as audits, investigations, inspections and licensure or disciplinary actions. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose medical information about you in response to a Court Order, Administrative Order and certain subpoenas.

Law Enforcement. We may release medical information to a law enforcement official about a death we believe may be the result of criminal conduct; about criminal conduct at AHC; and, in emergency circumstances, to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We

may also release medical information about individuals enrolled with AHC to funeral directors as necessary for these individuals to carry out their duties.

Military and Veterans. If you are a client of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or the law enforcement official.

OTHER USES OF YOUR MEDICAL INFORMATION: Other uses and disclosures of your medical information not covered by this Notice or required by the laws that apply to AHC, will be made only with your written permission (your written permission is referred to as an Authorization). If you provide your permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons indicated in your written Authorization. You understand that we are unable to take back any disclosures that we made before we received your written notice revoking your Authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your medical information. This includes your medical and billing records but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

To inspect or obtain a copy of your medical information, you must submit your request in writing to Access HealthColumbus, Inc., 61 Jefferson Ave., Columbus, Ohio 43215, Attention: Privacy Official.

We may deny your request in certain circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by AHC will review your request and the denial. The person conducting the review will not be the same person who initially denied your request. We will comply with the outcome of the review. In addition, if your request for access is denied, AHC will provide a copy of your medical information to a practitioner designated by you in your written request.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long the information is kept by or for AHC.

To request an amendment to your medical information, you must submit your request for an amendment, along with your reason for the request, in writing to Access HealthColumbus, Inc., 61 Jefferson Ave., Columbus, Ohio 43215, Attention: Privacy Official.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- (1) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- (2) Is not part of the medical information kept by or for AHC;
- (3) Is not part of the information you would be permitted to inspect and copy; or

(4) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made of your medical information. This list will not include disclosures that we made for purposes of treatment, payment and health care operations. We are also not required to include in this list the disclosures we made by acting upon your written Authorization.

To request an accounting, you must submit your request, in writing to Access HealthColumbus, 61 Jefferson Ave., Columbus, Ohio 43215, Attention: Privacy Official.

Your request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2004. The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family client or friend.

We are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request a restriction, you must submit your request, in writing to Access HealthColumbus, Inc., 61 Jefferson Ave., Columbus, Ohio 43215, Attention: Privacy Official. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work.

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

FOR FURTHER INFORMATION: For further information about the matters covered by this Notice, you may contact the Privacy Official at (614) 884-2440.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with AHC or with the Secretary of the U. S. Department of Health and Human Services. To file a complaint with AHC, you must submit your complaint in writing as follows:

Access HealthColumbus, Inc.
61 Jefferson Ave.
Columbus, Ohio 43215
Attention: Privacy Official

You will not be penalized for filing a complaint.