COMMUNITYHEALTH
CONNECT

Date Application Received: _____

Specialty: _____

NEW PATIENT CHECKLIST

Patient Name: _____ Date of Birth: _____

DO NOT RECEIVE APPLICATIONS THAT ARE NOT 100% COMPLETE.

☐ APPLICATION VERIFICATION INT: _____ DATE:_____

Initial & Date items completed

___ Patient *COMPLETELY* filled out Application

___ Income verification

___ Address verification

___ Referral from a PCP (for specialty medical care)

___ $20 paid – or Waiver Form completed

___ *REVIEW all documents to ensure* patient *QUALIFIES* for program

☐ SCAN DOCUMENTS & CHEWY PROFILE INT: _____ DATE:_____

___ Scan all *application documents* to T:\#scans – *scan separately (i.e. NEW, INC, REF, RES)*

___ GIVE ALL DOCUMENTS BACK TO PATIENT

___ Create *a* new patient *account* on CHEWY (**check for duplicates first**)

___ Upload all files *the patient account from the T:\ drive*

___ ****Delete scanned file from T:\#scans*****

☐ *OPEN NEW CASE* INT: _____ DATE:_____

___ *Open a new case for the specialty requested by the referral*

___ *Send Teams message to care coordinator letting them know about new case opened*

PATIENT CASE NOTES:

COMMUNITYHEALTH CONNECT

PATIENT COPY

Patient Responsibilities

Community Health Connect (CHC) is a nonprofit health access organization. We have contacted local physicians, dentists, and mental health specialists who are volunteering their services to help you get well and stay well. We are not an insurance company, nor is this a government or "entitlement" program. We work as patient advocates to coordinate care provided by these volunteers throughout the community. CHC does not pay for any services. We coordinate donated, or discounted care and all care must be pre-arranged thus excluding services such as emergency room visits and ambulance services. We will act as an advocate helping reduce health costs as much as possible, but ultimately you are responsible for your health and for the associated costs. Your responsibilities under this program, the services available, and other conditions of the program may change at any time. Our assistance may be terminated at any time and for any reason.

PLEASE INITIAL AT LEFT TO SHOW YOU UNDERSTAND EACH RESPONSIBILITY:

_____ I understand that CHC coordinates donated and discounted services, but that there will sometimes be additional associated bills due to lab, facility, anesthesiology, and other diagnostic services and fees, and that I am responsible for paying for these services. I understand that CHC will act as an advocate to reduce **all related healthcare costs** as much as possible but that ultimately my health, healthcare, and the associated bills are **my responsibility**.

_____ I will NOT schedule appointments with any CHC network provider (doctor, dentist, clinic, or hospital). All appointments will be made by the CHC care coordinator. If the provider schedules a follow-up visit, I will **notify** CHC **immediately**. I understand that if I have any questions or concerns with this policy, I may speak to my care coordinator, and they will review it on a case by case basis.

_____ I will be **responsible** for all **costs** incurred by visits that have not been scheduled by CHC staff.

_____ I understand that if I receive any **bills** in connection with any services provided from the CHC network, I must bring them in to the CHC office within **one week** of receipt if I want the assistance of a care coordinator in advocating for a discount or setting up a payment plan.

_____ I understand that I must follow the treatment plan provided by CHC service providers, and if I choose not to follow this plan, I will not be sent to an alternate provider, but will be dismissed from the program. CHC does not send patients for a "second opinion".

_____ I will promptly provide any health, financial, or personal information which may be requested by the program. If I do not provide requested information within 10 days my eligibility will be denied.

_____ I will apply for Medicaid or other assistance programs at the request of CHC.

_____ I will immediately contact CHC if my income changes or if I become covered by Medicare, Medicaid, private insurance, or other health insurance or medical benefits.

_____ I will **contact** CHC **immediately** with any changes in **address**, **phone number** or household **income**.

_____ I understand that the network providers are **DONATING** their services and I will behave myself appropriately while in their office, acting professionally and courteously, respecting the provider's time, their office, and their staff. I will show appreciation for the provider's services.

_____ I will turn **off** my cell phone during the appointment. I understand that the provider's office is not a day care facility and I will not bring unattended children to the office or facility.

_____ If I cannot make arrangements to get to an appointment, I will call CHC staff at least 24 hours prior to that appointment and cancel. I will In the case of surgery, I will call CHC 72 hours prior to the appointment to cancel.

_____ If I miss any appointment I will be dismissed from all CHC programs. I am aware that I will be able to plead my case to CHC management, and if they do reinstate my eligibility I will be required to pay a $25 fine.

_____ I understand that I am responsible to **arrive at ALL scheduled appointments on time.** If I arrive late and the appointment has to be rescheduled, I understand that it will be counted as a missed appointment (see above)

_____ I understand that if I miss a scheduled surgery I will be dismissed from the program immediately.

By signing below, I confirm that I understand and agree to the above conditions, and have received a copy of this form. If I do not follow the above guidelines, I may be terminated from CHC.

_____ _____

Signature of Patient, Parent or Guardian Date

COMMUNITYHEALTH CONNECT

For Office Use Only

☐ Medical _____

☐ Dental _____

Date of application _____

Application for Enrollment

Please submit the following with your completed application:

1) **Proof of Income** (copy of most recent IRS taxes, W-2, or two months of paycheck stubs)
2) **Proof of residence** in Utah County (lease agreement, utility bill, etc.)
3) **Referral from a primary care physician** for medical cases indicating medical need.
4) **$20 non-refundable membership fee** (eligibility for 6 months; renewable as required w/another fee payment)

PATIENT'S NAME: _____ **Date of Birth:** _____

Address: _____ **Age**: _____ **Sex:** M☐ F☐

City: _____ **State:** _____ **Zip:**_____ **Phone:** _____**Text Messages OK?** Yes☐ No☐

E-mail address: _____

Marital Status: Single☐ Married☐ Divorced☐ Separated☐ Widowed☐ **Name of spouse**: _____

Patient's Employment Status: Working Full-time☐ Part-time☐ Unemployed☐ Retired☐ Disabled☐ Student☐

Alternate Contact: _____ **Relationship:** _____ **Phone:** _____

Responsible Person (if patient is <18):_____ **Relationship:** _____

Address: _____ **Phone:** _____

Household Monthly Income

Number of individuals living in the home: Adults _____ Children_____

Type of income:	**Amount received per month:**
Responsible Party Employment Income (gross)	**$**
Spouse Employment Income (gross)	**$**
Other household members Employment income (gross)	**$**
Workers Compensation, SSI, SSA, Unemployment, Disability, Insurance income	**$**
Child Support, alimony, etc.	**$**
Received room, board, utilities paid by family, friends, church, etc.	**$**
Other: food stamps, WIC, etc.	**$**
TOTAL INCOME FOR ALL INDIVIDUALS IN THE HOME:	**$**

Does the applicant have dental insurance?

Yes☐ No☐ If yes, please name insurance company

_____

Does the applicant have medical insurance?

Yes☐ No☐ If yes, please name insurance company

_____

Are you or your children on CHIP, Medicaid or PCN? If yes, list

Names of individuals and type of coverage on back Yes☐ No☐

_____

Have you ever applied for Medicaid or Medicare?

Yes☐ No☐ If yes, when?

_____

Demographic Information (optional)

How did the applicant hear about Community Health Connect?

☐Volunteer Care Clinic ☐Mountainlands ☐School Nurse ☐Health Clinics of Utah ☐Health Department

☐Gappmeyer Clinic ☐Dixon Clinic ☐Dr. or Dentist name: _____ ☐other: _____

Ethnicity:

☐African-American ☐Asian ☐Caucasian ☐Hispanic ☐ American Indian ☐Pacific Islander

☐Other (please specify) _____

Level of Education:

☐Elementary School ☐High School ☐College ☐ Other

What are the specific medical, dental, or mental health symptoms for which you are seeking treatment through Community Health Connect?

_____

_

_____

Have you had diagnostic services for this particular need? (X-Rays, Blood Work, etc.) Yes☐ No☐

If yes, Name of Clinic: _____ Date/Type of Services: _____

Do you need an interpreter for your medical/dental appointments? Yes☐ No☐ If yes, what language: _____

Statement of Understanding

I understand that this application will be accepted only if the applicant meets the eligibility requirements. I authorize the release of any financial, medical or other information deemed necessary to Community Health Connect to determine eligibility. By signing this form, I authorize CHC to verify information provided. I certify that the information provided in this application is true and correct to the best of my knowledge.

_____ _____ _____

Signature of Applicant, Parent or Legal Guardian *(Relationship to patient)* *Date*

COMMUNITYHEALTH CONNECT

Agreement and Terms of Accepting Treatment

By signing below, I **(print name)**_____ agree that in exchange for receiving uncompensated health care services, I waive my right to sue or otherwise seek a monetary recovery from Community Health Connect, its employees, and health care professional volunteers for professional negligence except for acts or omissions that are grossly negligent or are willful and wanton, regardless of where such services are performed.

I have been provided the opportunity to ask questions or request further information from Community Health Connect regarding this statement and I understand fully the rights I am giving up.

I understand that this waiver has been made for the purpose of complying with Utah Code Annotated § 58-13-3 that permits me to waive my rights in exchange for receiving uncompensated health care services.

I acknowledge that I have seen, read, and understand the Notice of Limitation of Liability that applies to Community Health Connect and its employees and health care professional volunteers.

I acknowledge no guarantees to service have or will be made to me by either CHC or the health service providers to whom I have been referred by CHC as a result of examination or treatments and that enrollment in the program may be terminated at any time.

For Patients, Parent or Guardian of Patients under 18 Years of Age: This form has been explained to me, and I certify that I understand its contents and agree to the terms as stated above.

_____ _____

Signature of Applicant, Parent or Guardian *Date*

Notice of Privacy Practices

I have read and understand the *Notice of Privacy Practices* and I have been offered a copy.

_____ _____

Signature of Applicant, Parent or Guardian *Date*

Agreement to Follow Patient Responsibilities

I have read and understand the *Patient Responsibilities* form and have received a copy of it. I understand my responsibilities as a patient. If I do not keep my responsibilities, I may be dropped from CHC.

_____ _____

Signature of Applicant, Parent or Guardian *Da*

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:

Description of the Information to be Released

The Patient identified above authorizes the disclosure of all protected medical information in any form (including oral, written and electronic) to **Community Health Connect (CHC)** and Requestors' re-disclosure of the data and information to its agents, coordinators, physicians, hospital, and the entities and organizations specified below. Patient expressly request that all covered entities under HIPAA shall disclose full and complete protected health information concerning the patient. This includes, but is not limited to the following:

- All medical records, including, but not limited to: inpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, examination reports, office and doctor's handwritten notes, and records received from other physicians or health care providers
- All laboratory, histology, pathology, CT scan, MRI, echocardiogram reports
- All radiology films
- All pharmacy prescriptions, records
- All insurance and billing information

Organization Providing the Information	Organization to receive the Information
Community Health Connect	Dept. of Workforce Services Division of Child and Family Services Division of Services for People with Disabilities UVU Community Mental Health Clinic BYU Comprehensive Clinic Latino Behavioral Health Sydni Gibb/Melville Stables EAL Program Suncrest Counseling Mountainlands Community Health Center Primary Care Providers Specialty Physicians Mental Health Providers Health Clinics of Utah Utah Valley Hospital Mountainview Hospital Timpanogos Hospital Surgical Centers Family Haven School Districts State/Local Health Dept. (including WIC) Substance Abuse Treatment Providers Dental Providers Other _____ The Greenhouse Revere Health

Purpose for the use or Release of the Information

Release of this information is requested for the purposes of obtaining access to health care for those in need and to further the assessment and treatment of the patient.

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I understand that this authorization is voluntary.
- I have the right to revoke this authorization by sending a notice stopping this authorization to Community Health Connect at 591 South State Street Provo, UT 84606. The authorization will stop on the date my request is received.
- I understand that I am entitled to receive a copy of this authorization.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand that, after information is release under this authorization, it may be re-disclosed by the recipient, and if re-disclosed, the information will no longer be protected by federal or state privacy rules.
- I understand that I retain the right to refuse to sign authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization will be that personal information records, billing, or other sensitive information, will not be shared with outside partners, which will make it difficult for Community Health Connect to provide me with further treatment.
- Any facsimile, copy or photocopy of the authorization authorizes the release of all records requites herein.

_____	_____	_____
Signature of patient, parent or guardian	Relationship to patient	Date

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PATIENT COPY

So You've Turned in Your Application: What's Next?

- Call your coordinator within the first week of turning in the application. They will be able to give you an estimated time of how long it will be on the different wait lists.
- Once you are on the wait list, your Care Coordinator will be in touch with you when you are next on the list to see a doctor.
- If your information changes (ie- address, phone number, you receive more income) please let your coordinator know as soon as possible.
- If you find that you can get the care elsewhere, go on and pursue that. Let us know so we can take you off our lists and give the spot to someone else.
- Every six months you will need to bring in income verification, even if you haven't received services.

Medical:

- Once you are on the wait list, your Care Coordinator will be in touch with you when you are next on the list to see a doctor.
- **We do not do things on an urgent basis**. If you find that you need urgent care, please go to the Emergency Room.

Dental:

- The next step is to go to the Oral Health Education Class that we have once a month on the second Monday of the month at 6:30 pm. You only have to go to one class and the class is only half an hour long.
- *You must be on time, or you have to attend another class because the class is so short.*
- After you attend the class your Care Coordinator will be in contact with you to schedule a dental cleaning and exam. They will make a treatment plan that we will send on to the dentists.
- **Your name will not be added to the Dental wait list until you complete these two steps.**
- Once you are added to the wait list, you can check in every few months to see where you are on the wait list. Keep in mind that if you find another avenue to get your dental work done, work with that.
- **We do not do things on an urgent basis**. If you find that you are in pain, your Care Coordinator can provide you a list of low cost dental resources. Anything you get done outside of our program will come out of your own pocket.

Mental Health:

- **We do not do things on an urgent basis.** If you need immediate care:
  - **Always call 911** first and ask for a CIT Officer (Crisis Intervention Team).
  - **Utah Crisis Line:** 1-800-273-TALK
  - **National Suicide Prevention Lifeline:** 1-800-273-8255
  - **Latino Behavioral Health Services Hotline:** (385) 495-2188
  - **Veterans Crisis Line:** call 1-800-273-TALK (8255) press 1; or text 838255
  - **Crisis Text Line:** text the word 'Home' to 741-741
  - **The Trevor Lifeline for LGBTQ Youth:** call 1-866-488-7386
  - **The Trans Lifeline:** call 1-877-565-8860

2023 Income and Residency Verification

UTAH COUNTY Community Development BLOCK GRANT

Please complete the shaded sections of this form

Name of person in the program/receiving assistance

Address City Zip Code Phone

List each household member who lives in the home (including yourself):

	Name	Age	Sex	**Race** *(White, Asian, American Indian, Black, Pacific Islander)*	**Hispanic/ Latino Ethnicity** *(Yes or No)*	Relationship
1			M / F		Y / N	
2			M / F		Y / N	
3			M / F		Y / N	
4			M / F		Y / N	
5			M / F		Y / N	
6			M / F		Y / N	
7			M / F		Y / N	
8			M / F		Y / N	

* List any additional household family members on the back of this form.

Is the head of the household a single female? Y / N

Does anyone in the household have a physical or mental disability? Y / N

If yes, please describe the disability:

Note: All information given on this form will be kept in **COMPLETE CONFIDENCE** and used *only* for reporting general statistics to the U.S. Department of Housing and Urban Development.

How many people are in your household? _____

Find your household size in the table below, then circle the annual household income you make LESS THAN in that row.

1	$20,850	$34,700	$55,550	Over $55,550
2	$23,800	$39,650	$63,450	Over $63,450
3	$26,800	$44,600	$71,400	Over $71,400
4	$29,750	$49,550	$79,300	Over $79,300
5	$32,150	$53,500	$85,650	Over $85,650
6	$34.550	$57,500	$92,000	Over $92,000
7	$36,900	$61.450	$98,350	Over $98,350
8	$39,300	$65,450	$104,700	Over $104,700

In some cases, you may be required to attach a copy of last year's Federal Income Tax form or a copy of a current paycheck stub or another approved proof/verification of income.

I/We understand that the information provided on this document may be verified for accuracy and confirmation of eligibility to participate in this program funded by the U.S. Department of Housing and Urban Development. I/We certify that to the best of my/our knowledge this information is accurate and correct. The Administrators of this program may rely upon this information as confirmation of My/Our family's eligibility to participate.

Form completed by:

_____ X_____ _____

Name (please print) Signature Date