Healthcare Assistance Application

Great News!

Carousel is now part of CommUnityCare, a Federally Qualified Health Center. This means we can offer our patients more options to affordable healthcare. We have Financial Screening Specialists who are available to enroll you in the Sliding Fee Scale, MAP Basic or MAP program. We can also help you with your Medicaid and CHIP applications.

- **Benefits to enrolling in Sliding Fee Scale or MAP Basic Program:**
  - Routine medical and dental, $10.00 - $30.00
  - Medications $5.00 - $15.00
  - Once enrolled, your family can use the benefits at any of CommUnityCare's 23 locations. You can find us online at www.communitycaretx.org or request a location list at the Front Desk.

****Additional benefits available for patients enrolled in MAP, Medicaid and CHIP.****

- **You can apply for enrollment in 3 easy steps!**

Step 1: Complete a Healthcare Assistance application

Step 2: Gather required documents

Step 3: Submit Application & Documents

A list of required documents and instructions to submit are on last page of application.

A Financial Screening Specialist will review your application and supporting documents and within 3-5 business days, contact you to either: inform you of your enrollment or to request addition information if needed.

The information provided will be kept confidential and only be used to determine eligibility.

CommUnityCare HEALTH CENTERS

CAROUSEL PEDIATRICS

Healthcare Assistance Application

Step 1: Complete Application

Use this page to enter information about the parents (adults) related by marriage, including common law and declared living in the same house as the patient.

Adult or Parent 1 *(living in same house as patient(s))*

Full Name (First, Middle, Last) _____

Date of Birth: _____ Social Security Number: _____

Address (Street Number and Name): _____

Address (City, State, Zip Code): _____

If we need additional information for this application or have questions, how do you prefer to be contacted?

☐ Phone, list number: _____,best time to call: _____

☐ Email, list email address: _____

Check box next your legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_____

Has you earned income from working within the last 30 days? ☐ No ☐ Yes

Have you received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Retirement ☐ Unemployment ☐ Pension ☐ Survivors

Are you currently pregnant**:** ☐ No ☐ Yes

Do you have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: _____

Adult or Parent 2 *(living in same house as patient(s))*

Full Name (First, Middle, Last) _____

Date of Birth: _____ Social Security Number: _____

Check box next your legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_____

Has you earned income from working within the last 30 days? ☐ No ☐ Yes

Have you received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Retirement ☐ Unemployment ☐ Pension ☐ Survivors

Are you currently pregnant**:** ☐ No ☐ Yes

Do you have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: _____

CommUnityCare HEALTH CENTERS · CAROUSEL PEDIATRICS

Healthcare Assistance Application

Next, list information about the children related by birth or adoption living in your household under the age of 18. Do not include any children who are pregnant or have children of their own. *(**Note:** Children over the age 18 or who are pregnant or have children of their own can complete a separate application for enrollment.)*

Child

Full Name (First, Middle, Last) ____

Date of Birth: ________________ Social Security Number: ____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

Child

Full Name (First, Middle, Last) ____

Date of Birth: ________________ Social Security Number: ____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

Child

Full Name (First, Middle, Last) ____

Date of Birth: ________________ Social Security Number: ____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

CommUnityCare HEALTH CENTERS   CAROUSEL PEDIATRICS

Healthcare Assistance Application

Child

Full Name (First, Middle, Last) ____

Date of Birth: _________________ Social Security Number: _____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

Child

Full Name (First, Middle, Last) ____

Date of Birth: _________________ Social Security Number: _____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

Child

Full Name (First, Middle, Last) ____

Date of Birth: _________________ Social Security Number: _____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

If you have more children in your household that you need to list, you can download an "Additional Children" form from our website at www.carouselhealth.com under the Patient Resources tab or pick up from any Carousel.

Healthcare Assistance Application

Step 2: Gather Documents

These documents show proof of household size, income, address and citizenship and are required for each household member.

☐	**Proof of Address**	**A copy of one of the following, that list your address, dated within last 30 days:** • Utility Bill *(electric, gas, telephone, cable (no cell phone bills accepted))* • Rent Receipt, Printout or a Copy of Most Recent Lease Agreement • Current Driver's License or State ID • Any Personal or Business Mail or Envelope *(must include dated postal seal)*
☐	**Proof of Identity of Household Size** *(for each household member)*	**Each parent or adult living in household** • Photo ID *(Driver's License, State ID, Matricula Consular, Legal Permanent Residence card, Employment Authorization card, Passport or Visa)* **AND** • Birth Certificate/Records *(from any State/County)* **OR** Social Security card **Each child living in household** • Birth Certificate/Records *(from any State/County)* **AND** • Social Security card *(if they have one)*
☐	**Proof of Household Income** *(for each household member)*	**Income from work received within last 30 days** • Pay-Stubs *(including tips if applicable)* **OR** • Self-Employed or Paid by Cash, complete one of the following forms: **Self-Employment Statement** – If you count income and expenses. **Income with No Tax Deductions –** If you only count income. ***Both forms are available on the Carousel website at: www.carouselhealth.com , under the "Patient Resources" tab or can be picked up from any Carousel location. If you would like an emailed copy, please call Carousel at: 512-744-6000.*** **Other income received within last 30 days** • Most recent benefit award letter *(Social Security, Disability, Retirement, Unemployment, Pension, Survivors)* • Child Support Receipts or Office of Attorney General Report
☐	**Proof of Legal Status** *(for each household member)*	• US Birth Certificate • Certificate of Naturalization • US Passport • Voter's Registration Card

Step 3: Submit Application & Documents

Email to carouseleligibility@communitycaretx.org **OR** drop off at any Carousel location.

If you have any questions, call us at 512-744-6000 or email us at carouseleligibility@communitycaretx.org.

CommUnityCare HEALTH CENTERS
Sliding Fee Scale Program

MRN:_____

Applicant Responsibilities & Authorization

I certify that the information provided for eligibility determination is true and correct to the best of my knowledge, and understand it may be confirmed through a third-party vendor. I will notify CommUnityCare if there are any changes in my household size or income within ten business days.

I understand information provided will be used to determine if anyone in my household is eligible for enrollment in a local or state program that reimburses CommUnityCare for services provided to uninsured individuals. For example, Central Health's Medical Access Program (MAP) and MAP Basic.

I authorize the release of information provided to verify eligibility, if enrolled, in the bulk medication prescription assistance program (PAP) sponsored by drug companies that provide financial assistance to those that qualify.

I understand that I may need to email documents for program eligibility to CommUnityCare. If I send personal information by email, it may not be secure.

_____ _____
Applicant Signature Date

_____ _____
Spouse, Partner or Designee Signature Date

If designee, list relationship: _____

CommUnityCare HEALTH CENTERS
Programa de Escala Variable de Tarifas

Autorización y Responsabilidades del Solicitante

Certifico que la información provista para la determinación de elegibilidad es verdadera y correcta a lo mejor de mi conocimiento, y entiendo que puede ser confirmada por un proveedor externo. Notificaré a CommUnityCare si hay algún cambio en el tamaño o ingreso de mi hogar dentro diez días.

Entiendo que la información proporcionada se utilizará para determinar si yo o alguien en mi hogar es elegible para la inscripción en un programa local o estatal que reembolsa a CommUnityCare por los servicios a personas sin seguro. Por ejemplo, el Programa de acceso médico de Salud Central (MAP) y MAP Basic.

Autorizo la divulgación de información proporcionada para verificar elegibilidad, si soy inscrito, en el programa de asistencia de medicamentos recetados (PAP) patrocinado por compañías farmacéuticas que brindan asistencia financiera a los que califican.

Entiendo que es posible que puedo enviar documentos por correo electrónico para elegibilidad, el programa de CommUnityCare. Entiendo que no es seguro si envío información personal por correo electrónico.

_____ _____
Firma del Solicitante Fecha

_____ _____
Firma de Cónyuge, Pareja o Designado Fecha

Si designado, apunte relación: _____

Financial Screening Specialist Signature & Date:
☐Verbal consent obtained in lieu of written in order to safely provide care to the patient during the COVID-19 emergency.

MAP CENTRAL HEALTH MAP BASIC

APPLICANT RESPONSIBILITIES

Central Health's Medical Access Program (MAP) and MAP BASIC (collectively, Program(s)) help people access health care by paying for certain health care services. Whether you qualify for MAP or MAP BASIC depends on your income, where you live, the availability of other health care coverage, and the existence of alternate sources of payment for health care. Your ethnicity, color, religion, creed, national origin, gender, disabling condition, sexual orientation, or political belief(s) will not be considered and will not affect your eligibility for these Programs.

By my signature below, I swear that all the statements I have made in connection with my application for these Program benefits, including my answers to all questions about income, county of residence, and other payment sources are true and correct to the best of my knowledge and belief. I understand that, because my eligibility for these Programs is based on my answers to these questions, any omission, failure or refusal to provide Central Health with requested information, or giving false or misleading information in response to eligibility questions, may cause Central Health to terminate my Program benefits and to seek recovery of any payment Central Health made, on my behalf for health care services.

I agree to report any of the following life changes to Central Health within 14 days of the date of the change:

a. mailing address and telephone number
b. address where I live
c. any change in income that may affect my eligibility
d. number of people who live with me/ or a household member becomes pregnant
e. enrollment in Medicaid, CHIP, Medicare, or other private health insurance or notification that I am eligible for any coverage program that may pay for my care

If Central Health identifies an unreported change to any of these five material areas of my application, I understand that my Program benefits may be terminated and that Central Health can take any other action within its authority, including filing civil or criminal charges against me.

I understand that my enrollment in MAP and MAP Basic is conditioned on my agreement to allow Central Health to verify the statements I have made in connection with my application for Program benefits and that enrollment status may remain pending until such agreement is given and verification is obtained from a credible source (e.g., Social Security Administration or the Texas Workforce Commission). I further understand and agree that Central Health may request that I pay for a portion of the cost of my health care and that Central Health may recover any costs it paid for my health care from a third party in the event that I file a claim for personal injury damages.

Finally, I acknowledge and agree that my initials signify:

_____ My authorization for my employer, the Social Security Administration, the Texas Health & Human Services Commission, the Texas Department of State Health Services, and the Texas Workforce Commission to release benefits, enrollment, claims, wage, and other records to Central Health; and

_____ My authorization will be valid for a period of twelve months from the date I sign this Applicant Responsibilities form or until I revoke my authorization in a signed writing delivered to Central Health;

_____ My acknowledgement that I am responsible for ensuring that my mailing address, telephone number, and any cell phone number or email address I list beneath the next paragraph are accurate and are up to date (i.e. current) at all times during my Program enrollment; and

_____ (Optional) I understand there are risks associated with sending unencrypted text messages and emails, and I am providing my *consent* to receive information from Central Health regarding scheduled appointments, my application status, renewals and changes to Program coverage and benefits via—

☐ Cell phone. My current cell phone number is _____

☐ Email address. My current email address is _____.

Name of Applicant

Name of Personal Representative ("PR")

Signature of Applicant

Signature of Personal Representative

Program Identification Number

PR's Relationship to Applicant

Date

Date

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☐ Cell phone. My current cell phone number is _____

☐ Email address. My current email address is _____.

Name of Applicant

Name of Personal Representative ("PR")

Signature of Applicant

Signature of Personal Representative

Program Identification Number

PR's Relationship to Applicant

Date

Date