Access to Care
FILLING THE GAP FOR THE UNINSURED

Application Instructions

Enrollment Fee
Do not send now, Access to Care will send you an invoice. Annual non-refundable fees: $20 one adult member; $40 two adult members; $50 three or more adult members in one family.

Eligibility Requirements
- Live in suburban Cook County or Chicago (west of Pulaski Road and north of North Avenue);
- A family income under 300% of the federal poverty guidelines;
- No health insurance (or a deductible of $1,500 or more per person);
- Not eligible for public health programs such as Medicaid and Medicare

Registration by Mail
Fill out the inside of this form completely. All four (4) of these items must be mailed back to be registered for the Access to Care program. If documents are missing, your application cannot be processed.

1. **Proof of Support or Income:**
   - No Income: If you live rent-free, send a letter of room and board from the person you live with.
   - Employed: Copies of your last two (2) paycheck stubs for you and/or your spouse is required. Or an employer's letter of proof of income (for you or other family members).
   - Fixed Income: Proof of Social Security payments (for you and/or spouse).
   - Self-Employed: Copy of your most recent federal income tax form (1040) and your most recent profit and loss statement (Schedule C).
   - Unemployed: Copy of unemployment compensation statement for self and/or spouse.
2. **Proof of Address:** Copy of your lease; a utility bill; a driver's license; etc.
3. **Proof of Identity:** *This information is completely confidential and is only used to verify that you are not eligible for a more comprehensive medical program.*
   - Birth certificate, Social Security card, voters registration card, passport, naturalized citizenship certificate, permanent residency card, Visa, proof of US designation as a refugee, political asylum seeker, municipal ID, DACA ID or consular card.
4. **Signed Release Forms:**
   A signed Enrollee Acknowledgment and Release Form and Authorization Form is required with your application (sign both front and back).

If you have any questions please contact the Access to Care office: (708) 531-0680, or visit www.accesstocare.org.

****Access to Care is charity care, not insurance, it does not meet the individual mandate requirement under the Affordable Care Act.****

Instrucciones De Aplicación

Requisitos de Elegibilidad
- Vivir en los suburbios del condado de Cook o en Chicago (al oeste de Pulaski Rd Y al norte de North Avenue);
- Tener un ingreso familiar menos de 300% del nivel de pobreza nacional;
- No tener seguro médico o (seguro médico con un deducible de $1,500 o más por persona);
- No es elegible para programas de salud pública como Medicaid y Medicare

Cuota de Inscripción
No envíe el pago ahora, Access to Care le enviará una factura. Las cuotas anuales de inscripción no reembolsables son: $20 por un miembro adulto; $40 por dos miembros adultos; y $50 para tres o más miembros adultos en una familia.

Registración por correo
Por favor llene el interior de esta forma completamente. Debe devolver por correo los 4 requisitos para registrarse en el programa Access to Care. Si faltan documentos su solicitud no puede ser procesada.

1. **Prueba de Ingreso:**
   - No Ingreso: Si vive sin costo de alquiler, envíe una carta de alojamiento y comida de la persona con quien vive.
   - Empleado: envíe copias de sus últimos dos (2) talones de cheque de pago para usted y/o su cónyuge o una carta de comprobante de ingresos de un empleador (para usted u otros miembros de la familia)
   - Ingreso Fijo: envié copia de su comprobante de pago de Seguro Social
   - Su propio negocio: envíe una copia de la declaración de impuestos federales más reciente (1040) CON la forma de pérdidas y ganancias más reciente (Schedule C)
   - Desempleados: envíe una copia de la declaración de compensación por desempleo para usted y/o su cónyuge
2. **Prueba de Domicilio:** Envié una copia de su contrato de renta o recibo de luz, gas o teléfono o su licencia de manejo.
3. **Prueba de Identidad:** *Esta información es completamente confidencial y se usa para verificar que no es elegible para un programa médico más completo.*
   - Acta de nacimiento, Tarjeta de Seguro Social, Tarjeta de Registro de Votante, Pasaporte, Certificado de Ciudadanía y Naturalización, Tarjeta de Residencia Permanente, Visa, Prueba de Designación de los Estados Unidos como Refugiado o de Asilo Político, Tarjeta de identificación municipal, Tarjeta de identificación DACA, o Matricula Consular.
4. **Formas de Consentimiento:** Se requieren las formas de Conocimiento y Consentimiento y la forma de Autorización (firme los dos lados al frente y atrás).

Si tiene alguna pregunta por favor llame a la oficina de Access to Care: 708-531-0680, o visite www.accesstocare.org.

****Access to Care es atención de caridad, no un seguro médico, y no cumple con el requisito del mandato individual bajo la ley Affordable Care Act.****

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2225 Enterprise Dr. Ste 2507
Westchester, IL 60154

Application / Aplicación

BENEFITS: Doctor office visits $5 • Prescription medication $15–$40 • Lab tests and X-rays $5/test
BENEFICIOS: Visitas al médico $5 • Recetas médicas $15 - $40 • Laboratorio y Radiología $5/examen

FOR OFFICE USE ONLY / SOLO PARA USO DE OFICINA

Site ___ Income ___
Township ___ Emp. Status ___

Returning Access to Care members include membership number:
Si es miembro de Access to Care que regresa, escriba su número de membresía aqui:

____

1. PLEASE LIST FAMILY MEMBERS (INCLUDING YOU) APPLYING IN THE CHART BELOW.
(Family means you, your spouse, and your children under 21 living with you.) PLEASE PRINT CLEARLY.
Favor de enlistar todos los miembros de la familia (incluyendose usted) que desean inscribirse en ATC.
(*Familia significa usted, su esposa/o, y niños meñores de 21 anos de edad que viven con usted.)*
FAVOR ESCRIBIR CLARAMENTE.

Family Size Cantidad Familiar	Name (Last, First, MI) Nombre (Apellido, Nombre)	Sex Sexo	Date of Birth Fecha De Nacimiento	FOR OFFICE USE ONLY / SOLO PARA USO DE OFICINA								
				A/P/R	ETH	P.L.	INS	H	Phy Assign	Reg Date	Reen Date	Term RSN
1. Self Aplicante												
2. Spouse Esposa(o)												
3. Dependant Dependiente												
4. Dependant Dependiente												

*Indicate Family Size / Indique la cantidad familiar: ___________
If different than number of family listed above please explain / Si-es diferente de la cantidad de familia anotada anteriormente por favor explique: ______________________________

2. COMPLETE ADDRESS/Direccion:

______________________________ Street Address / Calle
______________________________ City / Ciudad
______________________________ Zip Code / Codigo Postal

______________________________ Phone Number / Numero de Telefonor
______________________________ Email Address / Correo Electrónico

3. ETHNICITY: Please check one:
☐ White ☐ African American ☐ Native Hawaiian, Pacific Islander ☐ Asian
☐ American Indian, Alaska Native ☐ Other ☐ Hispanic, Latino

Grupo Étnico:
☐ Blanco ☐ Africano Americano ☐ Nativo Hawaiano, Isleño Pacifico ☐ Asiático
☐ Americano Indige, Nativo de Alaska ☐ Otro ☐ Hispano, Latino

4. PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other ______________________________
Primer Idioma: ☐ Ingles ☐ Espanol ☐ Otro ______________________________

5. ARE YOU ELIGIBLE FOR PUBLIC AID? ☐ No ☐ Yes **If unsure call our office for screening.*
¿Es Elegible Para Ayuda Pública? ☐ No ☐ Si **Si no está seguro, llame a la oficina para saber.*

6. DO YOU HAVE HEALTH INSURANCE? ☐ No ☐ Yes If yes, what is your deductible? ______________
¿Tiene Seguro Médico? ☐ No ☐ Si Su respuesta es sí, ¿cual es su deducible? ____________

NOTES:______________________________

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ID#________________________________

SUBURBAN PRIMARY HEALTH CARE COUNCIL - ACCESS TO CARE PROGRAM

ENROLLEE ACKNOWLEDGEMENT AND RELEASE FORM

RIGHT OF APPEAL/GRIEVANCE PROCEDURE: I understand that I may appeal any decision regarding my eligibility for the Access to Care Program ("the Program") within 14 days of such decision by submitting in writing a grievance to the Suburban Primary Health Care Council ("the Council").

CIVIL RIGHTS: I understand that the Access to Care Program is an equal opportunity program open to all eligible persons regardless of age, race, sex, national origin, religion, disability, sexual orientation, or any other class of people protected by any federal, state, or local law. If I believe I have been discriminated against I may submit, within 14 days of the event, a written grievance to the Council.

DUAL PARTICIPATION: I have been informed that eligibility for the Medicaid program, the Medicare program, or receiving benefits under private health insurance for physician office visits may result in my termination from the Access to Care Program. I certify, that as of this date, I do not participate in the programs or receive the benefits described in the preceding sentence. I agree to promptly inform the Council if I begin to participate in such programs or begin to receive such benefits.

NON-TRANSFERABLE: I understand that enrollment is limited to the person(s) named on this application form and is not transferable. Giving my temporary or permanent identification as a Program member to any other person to use will result in my termination from the Program.

LIMITATION OF SERVICES: I understand and acknowledge the following:

A. Services provided by physicians under this Program are limited to a specific set of routine basic health care services which exclude, among other services, the following: some procedures normally provided by primary care physicians, service provided in the emergency room of a hospital, ambulatory specialty care and inpatient services.
B. A Non-Refundable Annual Enrollment fee of $20 for one person, $40 for two people or $50 for a family of three or more. Payment of the enrollment fee does not guarantee continued services for one year.
C. Physicians require payment by me of $5 per visit.
D. Pharmacies require payment by me of $15 per prescription for generic drugs, $30 per prescription for preferred brand name drugs and $40 per prescription for non-preferred brand name drugs. Prescriptions will be limited to a 30-day supply.
E. I must pay $5 for each lab and/or x-ray procedure.
F. Only certain physicians and pharmacies are participating in the Program and that for a variety of reasons certain physicians and pharmacies may leave the Program at any time.
G. That certain participating physicians may be unavailable because they do not have room for additional patients; (i) my physician may request that I be transferred to another physician and under certain circumstances the Council will grant such a request: (ii) if I or my physician request my transfer to another physician, it may take up to 60 days to provide me with a new physician; and (iii) my physician will not be available at all times and may refer me to another physician who is participating in the Program.
H. My participation in the Program will expire on the date of my Program membership card unless I meet the eligibility standards for the Program at that time and renew my participation in the Program. The Council has no obligation to advise me further of the date on which my participation in the Program will end or to initiate renewal of my participation. My participation in the Program may be terminated at any time that I am no longer eligible for the Program, as the Council may establish general standards for eligibility from time to time.
I. Changes in Program expenses or funding may require modification or termination of the Program at any time; therefore, access to Program services, even during my enrollment period, are not guaranteed.

HOLD HARMLESS: I acknowledge that neither physicians participating in the Program, nor any physician, clinic, or hospital to which I may be referred, are employees, agents, or partners of the Council and that the Council is not responsible to me in any way for the amount or quality of medical health care services which I may receive from a participating physician. I agree to hold harmless and release the Council and its directors, officers, employees and agents from any liability arising from the medical/health care services to which I gain access through the Program. I also agree to hold harmless and release the Council and its Directors, officers, employees, and agents from any liability arising from its arranging or attempting to arrange medical services for me through any health care provider or its payment of medical services on my behalf.

RELEASE OF INFORMATION: I consent to the release of any and all medical, social, and financial information, as well as the release of any and all information concerning eligibility for health insurance for myself and/or my dependents to the Council, its agents, contractors, and service providers with whom it maintains a relationship. I authorize the Social Security Administration to release any information concerning my eligibility for Medicare and Social Security benefits. I understand that the release of any medical information about me by the Council is limited by the Enrollee Authorization Form. I understand that I cannot become an enrollee of the Program until I sign this Enrollee Acknowledgment and Release Form and the Enrollee Authorization Form.

____
Member or Guardian Signature   Date

____
Spouse Signature   Date

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SUBURBAN PRIMARY HEALTH CARE COUNCIL - ACCESS TO CARE PROGRAM

ENROLLEE AUTHORIZATION FORM

I hereby authorize the Suburban Primary Health Care Council (‘the Council’) to use any medical information, which we refer to as “Protected Health Information,” about me in the following two ways.

1. If I choose to see a contracted health care provider, then the Council may assist that contracted health care provider in making a referral to another health care provider to provide me with treatment. I understand that, for example, a contracted doctor who I choose to see may send Protected Health Information about me to the Council so that the Council can refer me to another health care provider for additional services that the doctor says I may need. I understand that the Council will not use Protected Health Information that it receives in this manner for any purpose other than to refer me to another health care provider for additional treatment; and

2. I understand that the contracted health care providers who I choose to see will send the bills for their services to the Council for payment. I further understand that these bills will contain Protected Health Information about me. By choosing to participate in the Access to Care Program, I authorize the Council to obtain Protected Health Information about me from contracted health care providers who I choose to see so that the Council can pay for my health care. I understand that the Council will not use Protected Health Information about me it receives for any other purpose than bill payment.

This authorization is valid from the date that I chose to become a member of the Access to Care Program and ends on the date on which I stop being a member of the Access to Care Program. I understand that I have the right to revoke this Authorization in writing by notifying the Council that I have revoked this Authorization, but I also understand that if I revoke this Authorization, I will lose the benefits covered by, and will no longer be eligible for, the Access to Care Program.

I have had the opportunity to read this Authorization, and I understand what this Authorization means.

____
Printed Member or Guardian Name

____ ________________________________
Member or Guardian Signature Date

____
Printed Spouse Name

____ ________________________________
Spouse Signature Date

Feb 2021

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2225 Enterprise Dr. Ste 2507
Westchester, IL 60154