Access to Care
FILLING THE GAP FOR THE UNINSURED

Mail to: 2225 Enterprise Dr., Suite 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 (ATC) members include membership number:
Si es miembro de Access to Care (ATC) que regresa, escriba su número de membresía aqui:

____

1. Provide information for everyone in your family household who is applying for the Access to Care program.
Start with yourself, then your spouse/partner, followed by any dependents. Your dependents, potentially eligible for ATC, must be ages 19-26. Children ages 0-18 are not eligible. PLEASE PRINT CLEARLY.

Proporcione información para todos los miembros de su familia que solicitan el programa Access to Care.
Comience con usted mismo, luego con su cónyuge/pareja, seguido por cualquier dependiente. Sus dependientes, potencialmente elegibles para ATC, deben tener entre 19-26 años. Los niños de 0-18 años no son elegibles.

Family Size *Cantidad Familiar*	First Name *Primer Nombre*	Last Name *Apellido*	Middle Initial *Inicial de su Segundo Nombre*	Gender *Género*	Date of Birth *Fecha De Nacimiento*	FOR OFFICE USE ONLY / SOLO PARA USO DE OFICINA: A/P/R	ETH	PL	INS	H	Phy Assign	Reg Date	Reen Date	Term RSN
1. Self *Aplicante*														
2. Spouse *Esposa(o)*														
3. Dependent *Dependiente*														
4. Dependent *Dependiente*														

How many TOTAL family members are in your household? This means you, spouse/partner, dependents ages 19-26, AND children ages 0-18: ______

¿Cuántos miembros de la familia TOTAL hay en su hogar. Esto incluye usted, su cónyuge / pareja, dependientes de 19 a 26 años de edad y niños de 0 a 18 años: ______

2. ADDRESS/Direccion:

Street Address / Calle ____________ Apt # / Unidad # ____________ City / Ciudad ____________ Zip Code / Código Postal ____________

Phone Number / Teléfono ____________ Email Address / Correo Electrónico ____________

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

Grupo Étnico:
Por favor marque uno
☐ Blanco ☐ Africano Americano ☐ Hispano, Latino ☐ Asiático
☐ Indio Americano, Nativo de Alaska ☐ Nativo Hawaiano, Isleño Pacifico ☐ Otro

4. PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other ____________
Primer Idioma: ☐ Ingles ☐ Español ☐ Otro ____________

5. ARE YOU ELIGIBLE FOR PUBLIC AID? ☐ No ☐ Yes *If unsure call our office (708-531-0680) for screening.*
¿Es Elegible Para Ayuda Pública? ☐ No ☐ Sí *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 ☐ Sí Su respuesta es sí, ¿cual es su deducible? ____________

NOTES:____

Application Instructions

Enrollment Fee: Do not send now, ATC will send a bill. Annual non-refundable fees: $20 one member; $40 two members; $50 three+ members in one family.

Eligibility Requirements

- Live in suburban Cook County or Chicago (zip codes: 60630; 60631; 60634; 60639; 60641; 60646; 60656);
- A family income at or below 300% of the Federal Poverty Guidelines;
- No health insurance or insurance w/a yearly deductible of $1,500 or more per person;
- Not eligible for public health programs such as Medicaid and Medicare.

Not sure if you're eligible? Complete the application & let our staff assist you!

Apply on Online: www.accesstocare.org/application or **Apply by Mail with this Application**

Four (4) documents must be included with your application. **All documents are confidential.** They are used only by Access to Care (ATC) to make sure you are not eligible for other health care programs (eg, Medicaid) and live in an area we serve. If information is missing or you do not qualify for ATC, we will contact you.

1. **Proof of Support or Income:** *Needed for each person applying for the Access to Care program*
   - **No Income:** If you live rent-free, include a letter from the person you live with to confirm you live rent-free.
   - **Employed:** Copies of last 2 pay stubs or letter from employer stating your employment and income (for you and/or spouse).
   - **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 profit and loss statement (Schedule C).
   - **Unemployed**: Copy of unemployment compensation statement (for you and/or spouse).

2. **Proof of Address:** *For example, include one of the following to show you/your family's current address:*
   Driver's License ■ State ID ■ A bill: phone, cable, electric ■ Lease or mortgage ■ Other document w/current address

3. **Proof of Identity:** *Needed for each person applying for the Access to Care program*
   Birth certificate ■ Social Security card ■ Voter's registration card ■ Passport ■ Naturalized citizen certificate ■ Visa
   Permanent residency card ■ Designation of a refugee or politician asylum seeker ■ DACA ID ■ Other document

4. **Signed Release Forms:** *Include signed Enrollee Acknowledgment and Release & Enrollee Authorization forms (sign front & back).*

Questions? / ¿Preguntas? Access to Care: 708-531-0680 | apply@accesstocare.org | www.accesstocare.org

Instrucciones de Aplicación

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

Requisitos de Elegibilidad

- Vivir en los suburbios del condado de Cook o Chicago (códigos postales: 60630; 60631; 60634; 60639; 60641; 60646; 60656);
- Un ingreso familiar igual o menos al 300% del Nivel Federal de Pobreza;
- Sin seguro médico o seguro con un deducible anual de $ 1,500 o más por persona;
- No son elegibles para programas de salud pública, tal como Medicaid y Medicare.

¿No estás seguro si eres elegible? ¡Complete la aplicación y nuestro personal puede ayudar!

Aplique en Línea: www.accesstocare.org/application o **Aplique por Correo con esta Aplicación**

Se deben incluir cuatro (4) documentos con su aplicación. **Todos los documentos son confidenciales.** Solo los usa Access to Care (ATC) para asegurarse de que no sea elegible para otros programas de atención médica (por ejemplo, Medicaid) y viva en un área en la que prestamos servicios. Si falta información o no califica para ATC, nos comunicaremos con usted.

1. **Prueba de Apoyo o Ingresos:** *Necesario para cada persona que solicita el programa Access to Care*
   - **Sin Ingresos:** Si vive sin alquiler, incluya una carta de la persona con la que vive para confirmar que vive sin alquiler.
   - **Empleado**: Copias de los 2 últimos talones de pago o una carta del empleador que indique su empleo e ingresos (usted o su cónyuge).
   - **Ingresos Fijos:** Comprobante de los pagos del Seguro Social (usted o su cónyuge).
   - **Propio Negocio:** Copia de su declaración de impuestos más reciente (1040) y su estado de pérdidas y ganancias más reciente (Anexo C).
   - **Desempleado**: Copia de su declaración de compensación por desempleo (usted o su cónyuge).

2. **Prueba de Domicilio:** *Por ejemplo, incluya uno de los siguientes para mostrar su dirección actual o la de su familia:*
   Licencia de conducir ■ Identificación del estado ■ Un recibo: teléfono, electricidad ■ Arrendamiento o hipoteca ■ Otro documento

3. **Prueba de Identidad:** *Necesario para cada persona que solicita el programa Access to Care*
   Acta de nacimiento ■ Tarjeta de Seguridad Social ■ Tarjeta de registro de votante ■ Pasaporte ■ Certificado ciudadano naturalizado
   Visa ■ DACA ID ■ Tarjeta de residencia permanente ■ Designación de un refugiado o solicitante de asilo político ■ Otro documento

4. **Formas de Autorización:** *Incluya las formas firmadas de Autorización y Declaración de Reconocimiento y Exención de Responsabilidades (firmar frente y detrás).*

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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.

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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