Dear Applicant:

The HealthAssist program, part of nonprofit healthcare-coordination agency Access East, Inc., provides **low-cost access to specialty healthcare**. If you are a resident of **Beaufort**, **Pitt** or **Greene counties**, and are uninsured and meet the income requirements, you could qualify for HealthAssist, in which participating doctors donate their time and services to program enrollees.

HealthAssist *DOES NOT* pay for doctor visits, medical bills, or prescriptions.

HealthAssist offers such supportive services as:

- **Specialty Care**: If your primary-care doctor sends you to a specialist, you ***MIGHT*** be able to see that doctor **for a $30 co-pay, or at a reduced rate**.

- **Case-Management Services**: If you qualify for HealthAssist, you will be assigned a case manager who will assist you with getting the health services offered under the program. Case managers are available to talk with you about concerns you may have about your medical issues, and to help you explore available community resources. A case manager will work with you and your family to help you follow the treatment plan your doctor has given you.

- **Medication Assistance**: You might be eligible for community/state resources that help with medications. We have patient advocates who can assist you with applications.

★ HEALTHASSIST ***DOES NOT*** COVER EMERGENCY-ROOM VISITS, HOSPITAL IN-PATIENT CARE, OR AMBULANCE SERVICES, AND ***DOES NOT*** HELP WITH DENTAL CARE. WE RESERVE THE RIGHT TO CHECK ALL INFORMATION YOU HAVE GIVEN US. ★

Please complete the attached application in its entirety. If you have any questions, or need help filling out the application, feel free to contact us at (252) 847-2821. Please make sure to sign where a signature is requested, and tomail the completed application to:

HealthAssist
PO Box 6028
Greenville, NC 27835

Thank you very much for your interest in HealthAssist.

Mail completed applications to:
HealthAssist
PO Box 6028
Greenville, NC 27835
Questions? Call (252) 847-2821
Fax number: (252) 847-1928

ENROLLMENT APPLICATION

Client Name | Mailing Address | City | Zip | County

Phone # | Work Phone # | Date of Birth | Race | Sex

Emergency Contact: _____
Name | Relation | Phone

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widow

Social Security number / IRS Taxpayer ID (if applicable): _____

Do you have children under the age of 18? ☐ Yes ☐ No If yes, how many? _____

Do you currently have Medicare/Medicaid? ☐ Yes ☐ No Do you have a pending application? ☐ Yes ☐ No

Do you currently have health insurance? ☐ Yes ☐ No

Have you ever received health insurance, including Medicaid benefits? ☐ Yes ☐ No
If yes, when and why was it terminated? _____

Do you own real property (land, rights over land, and/or buildings) other than where you live? ☐ Yes ☐ No

Do you receive veteran's benefits? ☐ Yes ☐ No

Do you have a military-related disability and served for at least three years? ☐ Yes ☐ No

Do you receive Social Security disability or SSI disability? ☐ Yes ☐ No If so, which one? _____

Are you currently working? ☐ Yes ☐ No If no, what was your last date of employment? _____

Number of people in your household: _____ Name of employer: _____

Income: Your monthly employment income (before taxes): $ _____

Monthly income of other members of household (before taxes): $ _____
Other monthly income for household, including applicant (VA, unemployment, food stamps, child support, interest, other): $ _____

Total monthly income: $ _____
Frequency of pay (how often you are paid): _____

BELOW LINE, FOR OFFICE USE ONLY

Eligible: ☐ Yes ☐ No **Enrolled by:** _____ **Site:** _____

I understand that by enrolling in the HealthAssist plan that, from time to time, it is necessary for information regarding my identity, personal affairs, medical condition, and treatment to be discussed with personnel of other participating organizations whether by phone, fax, or in person, or by mail, email, or other means. I further understand that the information discussed is used for legitimate business purposes, such as treating a medical condition, enrollment, to ensure that I am able to keep my appointments, or for the better welfare of my family and myself. By signing this enrollment form, I hereby give my permission for matters regarding my identity, personal affairs, medical condition, and treatment to be discussed between personnel of any of the participating organizations for legitimate business purposes.

_____ _____ _____ _____
(Client signature) ***(Date signed)*** ***(Witness signature)*** ***(Date signed)***

CLIENT RESPONSIBILITIES

PROGRAM OVERVIEW:

HealthAssist is not a government program. Instead, area doctors, Vidant Medical Center, and many other local providers are offering their services to help you get well, and stay well. Note that our help may end at any time, for any reason.

HealthAssist does not cover emergency room or inpatient care, medications, or ambulance services. It also does not cover some lab tests that may be required by your doctor.

We reserve the right to check what you have told us, and we require that you pay for any help you may have received based on false information provided by you.

General:

You agree that you:

1. Will follow your treatment plan; for example, you will take medication as directed.
2. Will promptly supply any information that may be requested by the program.
3. Will know when your enrollment in the program ends. You will not use your card if you are not in the program.
4. Will allow all information regarding your participation in HealthAssist to be shared with other individuals, organizations, and agencies solely at the discretion of HealthAssist.
5. Will contact HealthAssist if your income changes, or if you become covered by Medicare, Medicaid, private insurance, other health insurance or medical benefits.
6. Will apply for Medicaid or other assistance at our request.
7. Will contact HealthAssist immediately about changes in income, address, or telephone number.

Referrals:

You agree to:

1. Call your primary-care doctor if you feel you need to be seen by a specialist. Referrals to a specialist **must be made** by your primary-care doctor.
2. Present your HealthAssist Patient ID card each time you see a participating specialist.
3. Contact your case manager with any questions about benefits **BEFORE** you go to a specialist or have a procedure.

I, the undersigned, release Vidant Medical Center, Brody School of Medicine, HealthAssist, Greene County Health Care, Agape Community Health Center, and the Eastern Carolina Community Health Consortium partners, as well as their employees, agents, and independent contractors, from any and all liability related to the provision of medical services, or for the release of my information (including medical information).

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

OFFICE USE ONLY

HA enrollment date: _____

HA termination date: _____

Patient's address:

_____

HEALTHASSIST Wellness Assessment
Adult Form (age 18-64)

Name: _____ Telephone number: _____

Date of Birth: _____ Age: _____ Sex: Male _____ Female _____
(Month/Day/Year)

1. Have you seen a doctor in the last 12 months? Yes / No
   If yes, then name of the doctor and his/her location: _____
   Is this your regular doctor? Yes / No
   If no, whom do you consider to be your regular doctor and his/her location: _____
   _____

2. Please check if you have or had, in the past 12 months, any of the following:

_____ Asthma _____ Emphysema/COPD/other breathing problems
_____ Diabetes/high blood sugar _____ Cancer _____ Stroke ____ Arthritis
_____ Back problems, other frequent pain issues _____ Heart problems _____ Seizures
_____ Pregnancy _____ High blood pressure _____ High cholesterol

3. Please list all of the medicines you take each day:

_____
_____
_____
_____

4. Do you use any special medical equipment or medical treatments? Yes / No
   Please check all that apply: _____ wheelchair _____ walker _____ glucose meter/blood-sugar tester
   _____injections/shots _____ oxygen _____ nebulizer/breathing machine _____ prosthesis
   Other special equipment: _____

5. Allergies to medications: _____

6. Please check all that apply to you:
   ___ Require language-interpreter services
   ___ Need transportation to doctor's office
   ___ Need eyecare
   ___ Need dental care
   ___ Smoker
   ___ Live with a smoker
   ___ Live alone
   ___ Have difficulty walking
   ___ Feel sad or unhappy a lot
   ___ Would like to lose weight
   ___ Need counseling services
   ___ Receiving counseling services
   ___ History of alcohol abuse
   ___ Do not have a place to live

7. What is your height? _____ What is your weight? _____

8. Signature: _____ Date: _____
   (Patient, or patient's guardian)

Signature Page

By signing this form I agree to:

1. My enrollment into the HealthAssist program and its Case Management Information System.

2. Give my permission for information about my identity, personal affairs, medical conditions, and treatment to be shared between employees of any of the participating organizations, physicians, and physician practices (whether by phone, fax, or in person, or by mail or other means) for legitimate purposes.

3. Notify HealthAssist immediately if I begin to receive **insurance, Medicaid or Medicare coverage**. I will accept financial responsibility for any medical services received under HealthAssist if I start insurance, Medicaid or Medicare.

_____	_____	_____	_____
(Client signature)	(Date signed)	(Witness signature)	(Date signed)

I release the following organizations and people from any and all liability related to the provision of medical services, or for the release of information (including medical information): Access East, Inc.; Vidant Medical Center; the East Carolina University Brody School of Medicine; Greene County Health Care and any other partnering agency; and the Eastern Carolina Community Health Consortium partners, as well as any of these entities' employees, agents, and independent contractors.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

HealthAssist representative: _____ Date: _____

Household information:

Please list ALL persons in your household by filling in the following information:

Name	Date of Birth	Relationship	Employer/Wage/Frequency

It is **VERY** important to include **ADULTS** and **CHILDREN** to create a complete application for HealthAssist programs.

Thank you.

Medicaid Screening Form

Screening date: _____

Name: _____ Date of birth: _____
(Month/Day/Year)

Address: _____

Phone #: _____ SSN/TTIN#: _____

PATIENT TO FILL OUT SECTION BELOW:
Circle the appropriate response:

YES / NO Are you pregnant?
YES / NO Are you under the age of 21?
YES / NO Are you the caretaker of a child under the age of 19?
YES / NO Are you disabled?
YES / NO Are you disabled as determined by the Social Security Administration or the state of North Carolina?
YES / NO Are you age 65 or older?
YES / NO Can your immigration status be documented?

I, the undersigned, attest to the fact that the above information is true to the best of my knowledge. I understand that, at the HealthAssist case worker's request, I must apply for Medicaid before being considered for HealthAssist. I also understand that I have the right to apply for Medicaid at any time, if I so choose.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____
(Required if patient signed name with an "X")

HEALTHASSIST CASEWORKER TO FILL OUT SECTION BELOW:
Circle the appropriate response:

YES / NO Was the patient assessed for Medicaid to meet HealthAssist requirements?