GCCN Eligibility Requirements

You must be a resident of Guilford County (minimum of 3 months, 6 months preferred)
You cannot be eligible for state or federal sponsored healthcare insurance, including:
Veterans Administration, Medicaid, Medicare, TRICARE, or the Affordable Care Act (ACA) Health Insurance Marketplace *(exemption required if eligible for the ACA)
Your annual income must be within 0-200% of the Federal Poverty Level (FPL)
If your annual income is 0-100% FPL, you must bring a Medicaid denial letter
*If your annual income is at least 100% FPL, you are first required to see if you are eligible to enroll in the ACA Health Insurance Marketplace before enrolling into the GCCN. www.healthcare.gov. If you are not eligible for ACA enrollment or are found exempt, you may then apply for the GCCN.

Picture ID

Valid Photo ID: driver's license, state identification card, passport, or identification from home country.

Proof of Guilford County Residency (choose one below) **(min. 3 months, 6 months preferred)**

NC Driver's License, learner's permit, or state-issued ID
Current utility bill with name and address (3 of the most recent)
Current county/city billing statement
Mortgage statement with address of residence/Lease agreement with the address of the residence, your name, and your landlord's name
If you are homeless, your shelter must give us a letter, on letterhead, stating you stay there. You must also have a picture ID that was issued at least three (3) months prior to enrolling

Proof of Income (All that apply, for each person in your household)

1040/Last year's tax return, W-2, 1099
Form 4506-T (If taxes were not filed for the previous year)
Notarized Schedule C for self-employment verification
At least four (4) current pay stubs and/or proof from employer
Other income: social security, unemployment, child support, workmen's compensation
Food Stamp Award Letter (if receiving assistance)—for Informational Purposes ONLY
Notarized Letter of Support (If you have no income and/or receive shelter from an individual/organization), PLUS three (3) months of utility statements from the residence where you are staying

Proof of Assets (All that apply)

Current Bank Statement (checking, savings, CD's, etc.)
If you are living on savings, you must provide three (3) of your most recent bank statements
Life Insurance Information (Cash Value/Company Name)
Pension, 401-K, IRA, Gross Amount, etc.
Tax value on autos, property, houses, mobile homes, etc.
If you applied for disability: Disability application and documentation (example: copy of award letter)

For College Students

Documentation (print-out) of how college is paid for (on school paper with logo)
Copy (print-out) of any award letters
Copy of parental tax return (if applicable)

NEW GCCN APPLICATION

Name: ____Date: _______________

(Last) (First)

Date of Birth: _______________________ Social Security #: _____________________________

Address: ____

City Zip Code

How long have you lived in Guilford County? _______________

Primary Phone #: ____________________ Alternate Phone #: ____________________

Emergency Contact:

____

(Name) (Relationship) (Phone #)

Do you reside in Guilford County? Yes☐ No☐

What is your main insurance? None☐ Medicaid☐ Medicare☐ Private Insurance☐ Other☐

Are you Hispanic or Latino? Yes☐ No☐ I choose not to answer☐

Race: Caucasian☐ African American☐ Asian☐ American Indian☐ Other☐ I choose not to answer☐

What language are you most comfortable speaking? ________________________________

Standardized SDOH Screening Questions (https://files.nc.gov/ncdhhs/documents/SDOH Screening-Tool_Paper_FINAL_20180405.pdf

Housing

Do you have housing? (Yes/No)

Are you worried about losing your housing? (Yes/No)

Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed? (Yes/No)

Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more? (Yes/No)

Within the past 12 months, did the food you bought just not last and you didn't have money to get more? (Yes/No)

Transportation

Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need? (Yes/No)

Interpersonal Safety

Do you feel physically and emotionally safe where you currently live? (Yes/No)

Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone? (Yes/No)

Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? (Yes/No)

Urgent Need(s)

Are any of your needs urgent? For example, I don't have food for tonight, I don't have a place to sleep tonight, I am afraid I will get hurt if I go home today? (Yes/No)

Family Members

How many family members, including yourself, do you currently live with? ____________

List all household members below, beginning with yourself.

Household member information		
Name	Date of Birth	Relationship
		SELF

Bank Reference:

Savings with: _________________ Account #:____________________ Estimated balance: ________

Checking with: ________________ Account #:____________________ Estimated balance: ________

Everything I have stated in this application is correct to the best of my knowledge. I understand that this application is required for the purpose of my obtaining access to the Guilford Community Care Network (GCCN) and I authorize the GCCN to check my credit report, employment history or any other information appearing on this form. If I provide false information, I will not be eligible for services through the GCCN for a period of one (1) year from the date indicated below. By signing this form, I authorize the use of my social security number and contact with my family members for the purpose verifying information supplied on this form.

Applicant's / Guarantor's Signature: ___________________ Date: ___________________

For Office Use Only:

Eligibility staff signature: ______________________________ Agency name:____________________________

Eligibility staff phone number and extension: _______________________________________

Please indicate if a Medicaid application was performed: (Y or N)

Client Authorization to Release and Share Information

Definition of Guilford Community Care Network:

Guilford Community Care Network is a partnership operating as an Organized Health Care Arrangement (list of member agencies available upon request). The following organizations are part of the GCCN (but not limited to): Cone Health System, High Point Regional UNC Health Care, Guilford County Department of Health and Human Services, Triad Adult &Pediatric Medicine, Inc., Eagle Physicians, LeBauer Healthcare and the Partnership for Community Care. By signing this form, you consent to the use or disclosure of your protected health information or that of your dependent(s) by all member agencies of the GCCN in order to carry out treatment, payment or health care operations. You have or your dependents have the right to review the GCCN's partner's privacy practices prior to signing this consent form. You also understand that GCCN uses a number of automated systems and that these systems may call the home of the person being treated if an appointment is scheduled. By signing this form, you also give the GCCN permission to call your home or the home of one of the persons listed above in regards to an appointment for your care or the person whom care is being requested. The partners of the GCCN work together and may disclose medical information about you or your dependents to each other. By doing this, it helps to ensure consistent, quality, medically appropriate and cost-effective healthcare services.

Purpose of Release and Sharing Information:

The purpose of this Authorization is to allow staff of GCCN Agencies to take necessary actions to meet my needs, and the needs of any minors for which I am responsible, through coordinated service identification, planning and deliver.

Protection of Information to be shared:

We (GCCN agencies) protect the information in GCCN by strictly limiting who has access to your personal information. We require all Network Agencies and Network Agency authorized staff members to sign confidentiality agreements to maintain the security of your information.

Authorization to Release and Share Information:

I hereby give my consent for my information to be entered into the GCCN electronic database and shared with Network Agencies to be used for my care coordination, treatment, and service delivery evaluation. A list of Network Agencies is available to me upon my request. My information will remain confidential and will not be used for marketing or solicitation purposes – or shared with any individuals or agencies outside of GCCN – without additional written authorization from me. I understand that I can refuse access to part or all of my information, and may limit access to certain Network Agencies, at any time by written statement. If I choose not to give my consent, my refusal will not prevent me from receiving healthcare services from the GCCN network agency and its staff. GCCN reserves the right to deny non-healthcare services based on their individual policies and procedures (Social Services Agencies). GCCN reserves the right to add agencies from time to time in order to provide me with more opportunities for assistance. **I hereby authorize the release and sharing of my individually identifiable information. I understand that this authorization will expire one (1) year from the date of signature below.**

Release from Liability:

I HEREBY RELEASE GUILFORD COUNTY, GCCN HEALTH DATABASE, P4HM AND THE NC ADVANCED HEALTH PROGRAMS AND ALL OTHER NETWORK AGENCIES THAT PARTICIPATE NOW OR IN THE FUTURE, FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF MY INFORMATION.

Alcohol/Drug/Infectious Disease/Mental Health records:

The parties to this agreement understand these records are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initiated below. **I UNDERSTAND** that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and mental illness including treatment of alcohol or substance abuse. The following information **will not be excluded** from our information sharing network: 1) sexually transmitted diseases, 2) acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection. GCCN requires that mental health and substance abuse information be shared in order to provide you with quality care. If you do not wish this information to be shared, you will be unable to participate in the network.

Signature:____ Date:___________________

Applicant or Legal Representative

Agency Restriction:

I understand that restricting release and sharing my information may limit the ability of the Network Agencies to provide care coordination and treatment for me or any minors for which I am responsible. If I do not wish my medical information to be shared with an individual provider/agency, I must notify my primary care provider.

Right to Revoke Authorization:

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION REQUEST.

Signature:

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.

Applicant signature: ____ Date:__________________

Parent, Guardian/Legal Representative Signature: _______________________________________

Printed Name: ____________________________ Relationship to Client: ___________________

Eligibility Period:

Patient Name:	Patient DOB:
Agency Rep's Name:	Rep's Phone #
Level %:	Other Coverage:
City of Residence:	Household Information:

Patient Responsibility Form

Program Overview

Guilford Community Care Network (GCCN) is a community-based partnership administered by Guilford Adult Health, Inc. with the goal of improving the coordination of healthcare services offered by the community's safety net providers. GCCN doctors, area clinics, pharmacists, hospitals and many others are volunteering their services to establish a patient centered medical home for you. This is not a government program or an "entitlement." Our help may end at any time, for any reason. The GCCN **does not** cover Emergency Room Expenses, Urgent Care Services, Ambulance Services and Inpatient Stays but provides access to care. Your responsibilities under this program, the assistance available and other conditions of the program may change at any time. By signing this form, you authorize the GCCN to verify what you have told us with state and other agencies. We reserve the right to require that you pay for any assistance you may have received based on inaccurate information provided by you.

General

You agree that you:

1. Will not schedule appointments with any specialists, clinics, or hospitals. **Any appointments made by patient will be patient's responsibility.**
2. Will follow your treatment plan, for example get prescribed medicines and take as directed.
3. Will promptly supply any information that may be requested by this program.
4. By signing this form, you consent to the use or disclosure of your protected health information or that of your dependent(s) by the GCCN in order to carry out treatment, payment or health care operations. GCCN is a partnership operating as an Organized Health Care Arrangement.
5. Will immediately contact the GCCN 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 programs at our request.
7. Will contact the GCCN immediately with any changes in address or phone number.
8. Will keep your GCCN eligibility current and up to date.

Referrals

You agree to:

1. **Keep each doctor's appointment. It is the patient's responsibility if he/she needs to change an appointment. The patient must call the specialty office FIRST where the appointment is scheduled no less than 2 work/business days prior to the scheduled appointment time. Then the patient must call P4CC and notify of the update within 2 work/business days prior to the scheduled appointment time. If the patient does not call to cancel or reschedule 2 work/business days before the appointment time**

this is considered a No Show. The patient must wait 6 months before another specialty appointment can be made. Guilford Dental Access Program policy is separate from this policy.

2. **Present your GCCN Patient ID card each time you see a doctor.**
3. Call your primary care physician if you need any additional referrals. If you go to a doctor who does not participate with the GCCN, **you will be financially responsible for any charges incurred**.

Medication Assistance

You understand that:

1. Your ID card will help you get assistance with medications that are on the GCCN's formulary. Co-Pay will be listed on your ID card. Not all medications are available through this program. Please share the GCCN formulary with your physician so that he/she may be able to choose a medication listed on the formulary.
2. You will only be able to pick up medications covered under the GCCN at the approved location provided by your eligibility and enrollment specialist.
3. You are to present your ID card each time you have a prescription filled.
4. You must keep your GCCN eligibility current.

The GCCN does not guarantee appointments at any healthcare provider. By signing below, you confirm that you understand and agree to the above conditions. If you do not follow the above guidelines, you may be terminated from the GCCN.

Signature: ____ **Date:** _______________________________________