Guilford Community Care Network
Assuring Access to Healthcare for All

10/2015

APPLICATION

Full Name*: ____Date: ____________________

Date of Birth: ______________________________ Social Security #: __________________________

Address: ____
City Zip Code

Length of Time at Residence: ____________________ Driver's License #: ______________________

Home Phone #: ______________Work Phone #: ____________Email Address: ____________________

***To avoid delays in processing be sure to record the applicant's official full name**

Guarantor 1/Guardian's Name 1: ___________________________________ Date of Birth: __________

Address: ____Social Security #: ________________

Home Phone #: ______________ Work Phone #: ____________Email Address: ____________________

Do you reside in Guilford County? Yes O No O County residing____________________

Do you live in a: O Doubling up (two or more) O Shelter O Transitional Housing O Street/Vehicle

O Homeless O Not Homeless

Public Housing: O Family tenant O Section 8 O Senior Housing O Vicinity of Section 8 O N/A

Employment: O Full-time O Part-time O Self-employed O Unemployed O Disabled O Retired

Members of your household unit: (Name/Date of Birth/Relationship – Also include Significant Other)

Household member information			Household member information		
Name	DOB	Relationship	Name	DOB	Relationship

Do you or own any property, investments, and/or bank savings (Please describe below)?

Name of Assets	Type	Use	Location	Value
Real Estate				
Other Real Estate				
Automobile				
Automobile				
Other (Personal Property, stocks, bonds, CDs, etc.				
Other				
Other				

Do you require translation/interpretation services? Yes O No O Please Specify____________________

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)

Date Medicaid application received___________________

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 Health Care 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, CMIS, 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: _______________________