Guilford Community Care Network

Assuring Access to Healthcare for All

		Eligibility Period:
Patient Name:		Patients DOB
Agency Issuing this Card:		
Agency Rep's Name:		Rep's Phone #
Level %:		Other Coverage:
City of Residence:		Household Information
Guardian's Name		
M/R #		Provider Name
CMIS Identifier	Co-pay	RX Co-pay

Please present this card with a picture I.D.

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**.

Medications 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:** _____