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Guilford Community Care Network
Assuring Access to Healthcare for All

GCCN Eligibility Requirements

- You must be a resident of Guilford County (minimum of 3 months, 6 months preferred)
- You cannot be eligible or currently enrolled in state or federally sponsored healthcare insurance, including: Veterans Administration, Medicaid, Medicare, TRICARE, or the Affordable Care Act (ACA) Health Insurance Marketplace *(exemption required if not 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 you are unable to bring in the denial letter, please notify the enrollment staff.
- If your annual income is at/above 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.
- If you attend a College or University with a Health Center, you would not qualify for the program.

Proof of Guilford County Residency (All That Apply) min. 3 months, 6 months preferred

- ***Required** Valid Current Photo ID: NC Driver's License, state identification card, passport, or identification from home country.
- Current utility bill with name and address
- Current county/city billing statement
- Current Mortgage statement with address of residence/current lease agreement with the address of the residence, your name, and your landlord's name
    - If you live with someone you must provide a notarized letter with the address included and current utility bill from that person
- If you are unsheltered, your shelter/residential agency must give us a letter, on letterhead, stating you stay there. (Ex: a letter from the IRC stating that you're unsheltered).

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

- 1040/Last year's tax return, W-2, 1099
- Form 4506-T/ Verification of non-filing tax status (If taxes were not filed for the previous year)
    - Call: 1-800-908-9946; Address: 4905 Koger Blvd Greensboro; Visit www.IRS.gov/transcript
- **Notarized** Schedule C for self-employment verification
- Last **90 days** of pay stubs for each working member of the tax filing household
    - Plus, proof from employer showing if you are paid weekly, biweekly or monthly
- 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
- Documentation of Financial Reward on official letter head
    - Not applicable for students attending a college or university with a Health Center
- **If you applied for disability**: Disability income information

Proof of Assets (All that apply)

- **Current** and **Complete** Bank Statement from the **last 90 days** (checking, savings, CD's, etc.)
- Whole Life Insurance Information (Cash Value/Company Name)
- Pension, 401-K, IRA statements showing current value, Gross Amount, etc.

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GCCN APPLICATION Date: _____

Name:

_____

(Last) (First)

Date of Birth: _____ Last 4 of Social Security (if applicable): _____

_____

(Address) (City/State) (Zip Code)

How long have you lived in Guilford County? _____

Primary Phone #: _____ Alternate Phone #: _____

Do you have a bank account: Yes☐ No☐

Marital Status: Single☐ Married☐ In a Domestic Partnership☐ Divorced☐ Widowed☐

Gender: Female☐ Male☐ Transgender Female to Male☐ Transgender Male to Female☐ Prefer Not to Say☐

Do you reside in Guilford County? Yes☐ No☐

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

Have you applied for Medicaid? Yes☐ No☐

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

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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

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**: _____

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, Wake Forest University High Point Regional, Guilford County Department of Health and Human Services, Triad Adult & Pediatric Medicine, Inc., Eagle Physicians, LeBauer Healthcare, Mustard Seed and Family Service of the Piedmont, NC Health Care Foundation. 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 regard 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:

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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, NCHF 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**: _____

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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) and Guilford Dental Access Program 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 a grant funded program and criteria to enroll for access are subject to change. The GCCN **does not** cover Emergency Room Expenses, Urgent Care Services, Ambulance Services and Inpatient Stays but provides access to coordinated 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 verify that all information presented is accurate. 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. You will call to establish with your assigned primary care home located on the front of your Orange Card.
2. Will not schedule appointments with any specialists, clinics, or hospitals. **Any appointments made by you will be your financial responsibility.**
3. Will follow your treatment plan, for example get prescribed medicines and take as directed.
4. Will promptly supply any information that may be requested by this program.
5. 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.
6. **Will immediately contact the GCCN if your income changes or if you become covered by Medicare, Medicaid, private insurance, other health insurance/medical benefits.**
7. Will apply for Medicaid Health Coverage or other assistance programs at our request or as needed. (exemption required if not eligible for the ACA)
8. Will contact the GCCN immediately with any changes in address or phone number.
9. Will keep your GCCN eligibility current and up to date.
10. You must call the GCCN Administrative Office to confirm any specialty care appointment. If not confirmed your appointment may be cancelled.

Referrals

You agree to:

1. Keep each doctor's appointment. It is your responsibility to change/cancel an appointment. You must FIRST call the administrative office of GCCN and notify within 2 work/business days prior to the scheduled appointment time. If you do not call to change or cancel 2 work/business days before the appointment time, then this is considered a No Show. You must wait 6 months before another specialty appointment can be made.

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2. **Guilford Dental Access Program policy: If you have 2 no show appointments then you will be unable to schedule for the next 6 months. If you no shows for a 3rd time after the 6 month suspension, then you will be discharged from the Dental Clinic.**
3. Present your GCCN Orange Card and Picture ID each time you see a doctor and any associated fees/co-pay (if applicable).
4. Call your primary care physician if you need any additional referrals. If you go to a doctor who does not participate with the GCCN or schedule your own specialty care appointment, **you will be financially responsible for any charges incurred**.

Medication Assistance

You understand that:

1. Your GCCN Orange Card and Picture ID will help you get assistance with medications that are on the GCDHHS Pharmacy formulary. The co-pay will be listed on your GCCN Orange Card. Not all medications are available through this program.
2. You will only be able to pick up medications available on the formulary at the approved location provided by your eligibility and enrollment specialist.
3. You are to present your GCCN Orange Card and Picture ID each time you have a prescription filled.
4. You must keep your GCCN eligibility current and follow medication assistance program requirements.

GCCN Rude, Angry, or Disgruntled Patients Policy/Violation of Enrollment Policy

You understand that:
Patients, family members, and other visitors displaying any of the following behavior mentioned below (in person or on the telephone) will undergo formal corrective action ranging from a written warning to being discharged from the practice.

1. Conduct which disrupts
    a. efficient and orderly operations of clinic
    b. ability of employees doing their job
    c. Abusive/vulgar language towards staff members or visitors at the clinic
    d. the environment of the dental clinic
2. Behavior
    a. that is threatening and intimidating
    b. that results in fighting on premises
    c. that results in intentional damage or attempting to damage clinic or private property
    d. that's results in sexual abuse or harassment
    e. from the result of being under the influence of alcohol or drugs
3. Theft or unauthorized possession or removal of clinical items or private property
4. Falsification of records or documents
5. Possession, use, selling, and/or delivery of
    a. firearms or weapons on clinic property
    b. any controlled or unauthorized or illegal substances or drug paraphernalia on clinic property

You understand that:

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:** _____