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Description automatically generatedHealthcare Access Program

**Registration/Referral Form**

Thank you for your interest in the (HAP) HealthCare Access Program!

The HAP program is designed to improve health outcomes and enhance the quality of life for low-income and underinsured individuals with chronic illnesses by addressing financial and logistical barriers to health, helping community members afford lifesaving treatments, healthcare and health insurance.

Through this program we provide the following assistance:

* Healthcare Enrollment Services – helping participants enroll into Medi-Cal, Medicare, and Covered California
* Healthcare Insurance Payment Assistance – providing financial support for qualified individuals
* Medication Payment Assistance – providing financial support for qualified individuals

*Qualifying medical conditions:*

According to the CDC, a chronic disease is a condition that lasts 1 year or more and requires ongoing medical attention or limits daily living or both.

**Eligible clients must have three of the following chronic diseases: Cardiovascular Diseases:** Coronary Artery Disease, Heart failure, recent heart attack, Hypertension

**Chronic Respiratory Disease:** Asthma, Emphysema, Chronic Bronchitis, Chronic Obstructive Pulmonary Disease

**Cancer:** Breast, Prostate, Lung, Colon, Brain

**Chronic Kidney Disease**

**Musculoskeletal Disorders:** Osteoarthritis, Rheumatoid Arthritis, Osteoporosis

**Neurological:** Parkinson's Disease, Multiple Sclerosis, Alzheimer's Disease, Epilepsy, Recent Stroke

**Chronic liver diseases**

**Autoimmune diseases:** HIV, Systemic Lupus Erythematosus (SLE), Multiple Sclerosis, Crohn’s Disease, Ulcerative Colitis

**Mental**: Depression, Bipolar, Schizophrenia

If you are living with three or more of these chronic conditions, we encourage you to contact us today to learn more about how you can access affordable healthcare tailored to your needs.

*Other factors taken into consideration:* Mobility restrictions, sensory impairment, low life expectancy, advanced age, and extremely low or high body weight.

\*Assistance is limited to a maximum amount per household.

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| **For Healthcare Insurance Enrollment Service contact:** | **For Financial assistance with Health Insurance and prescriptions contact:** |
| Ashley@cabenefitssupport.com | Pam@cabenefitssupport.com |
| 562-673-6422 | 562-518-9820 |

**Application type**: 🞏Medi-Cal 🞏Covered California 🞏Medicare

🞏Health Insurance Payment 🞏Prescription Payment

🞏Initial Application 🞏Renewal Application

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| 1. **PERSONAL INFORMATION** |

|  |  |  |
| --- | --- | --- |
| Full Name: | | Date of Birth: |
| Homeless? 🞏Yes 🞏No | | SSN: |
| Qualifying Medical Condition(s): | | |
| Address: | | |
| Phone: | Email: | |
| Language: | Are you a Veteran? 🞏Yes 🞏No | |
| Do you receive Veteran Benefits? 🞏Yes 🞏No | If yes, how much do you receive? | |
| U.S. Citizen? 🞏Yes 🞏No If No, will need front and back copy of Green Card | | |
| Race: 🞏Asian American or Pacific Islander 🞏Black 🞏Latinx 🞏Native American 🞏White 🞏Other | | |
| Gender: 🞏Male 🞏Female 🞏Trans MTF 🞏Trans FTM 🞏Non-binary 🞏Other | | |
| Monthly Income from all sources: |  | |
| Medical Insurance Provider: | | |
| If applicable, Medi-Cal Number: | Medi-Cal Carrier: | |
| Have there been 2 or more E.R. visits/inpatient stays during the previous 12 month? Yes No  If yes, explain | | |
| Monthly Health Insurance Cost: | | |
| Number of prescriptions: | Cost of monthly prescriptions: | |
| How much is your current out-of-pocket costs? | | |
| List prescriptions along with cost(s):   1. Prescription 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 2. Prescription 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 3. Prescription 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 4. Prescription 4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 5. Prescription 5: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 6. Prescription 6: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 7. Prescription 7: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 8. Prescription 8: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 9. Prescription 9: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 10. Prescription 10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 11. Prescription 11: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ 12. Prescription 12: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cost: \_\_\_\_\_\_\_\_ | | |

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| 1. **REFERRER INFORMATION** |

I agree that anyone listed below may be contacted by California Benefits Support Center regarding my application or services.

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| Referred by: 🞏Self 🞏Other | | | |
| If Other: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Name of Doctor:** | | Name of Facility: | |
| Address: | Phone: | | Email: |
| **Name of Case Manager/Social Worker & Facility:** | | | |
| Address: | Phone: | | Email: |
| **Name of Caregiver/Emergency Contact:** | | | |
| Address: | Phone: | | Email: |
| **Name of Pharmacy:** |  | |  |
| Address: | Phone: | | Email: |
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| 1. **CONSENT AND AGREEMENT** |

By signing this authorization, I allow California Benefits Support Center to collect, share, and disclose my personal and sensitive information for the purpose of applying for public benefits, health insurance, and other necessary services to assist with my case. These may include but are not limited to programs such as CalFresh (SNAP), Medi-Cal, and other health and social services.

**Information to be Released**

I authorize the release of the following information:

* Full legal name, date of birth, and social security number
* Financial information such as income, assets, and resources
* Employment and educational information
* Medical history and health status, including disability documentation, if necessary
* Any other information required to apply for and manage public benefits and health insurance

**Entities Authorized to Receive and Share Information**

The information specified above may be disclosed and shared between:

* California Benefits Support Center
* Government agencies, including but not limited to the Department of Social Services, Health Care Agencies, and other public assistance programs
* Health insurance providers and healthcare facilities as necessary
* Third-party contractors or partners that assist with benefit applications or health insurance enrollments

**Duration of Authorization**

This authorization is valid from the date of my signature until:

☐ The date my application process is completed, and I am enrolled in applicable benefits.  
☐ I revoke it in writing.  
☐ Specify another date or event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Revocation of Authorization**

I understand that I may revoke this authorization at any time by notifying **California Benefits Support Center** in writing. I also understand that revoking this authorization will not affect any action taken before my written revocation is received.

**Client’s Rights and Understanding**

* I understand that I am not required to sign this form to receive assistance from **California Benefits Support Center.**
* I understand that this authorization is voluntary and that I may refuse to sign it. However, refusal may impact my ability to receive assistance with benefits and health insurance applications.
* I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.

**Legal Release**

I agree to release, hold harmless, and indemnify California Benefits Support Center, its Board, employees, volunteers, and agents from any liability, cost, claim, or damage of any kind from my application or service.

**Complaints:**

The Director of the program can be contacted at any time with any complaints, which will be reviewed and responded to. The Director can be reached M-F 9am to 3pm at admin@cabenefitssupport.com We respond to inquiries within 24 hours.

**Signature of Client or Legal Representative**

I have read and understand the terms of this release form. I agree to the disclosure of the specified personal information for the purposes outlined above.

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **MEDICAL INFORMATION (FOR HEALTH CARE PROVIDER)**

*Please have your doctor’s office complete this form (Sections D, E, & F)*

*the General Information section and any applicable Qualifying Medical Information sections.*

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| Are there any mobility restrictions (e.g., bedbound, wheelchair, walker, cane, Medi-Access, loss of limb, loss of sensory ability)? If yes, list all that apply: |
| Is life expectancy estimated to be six months or less? 🞏Yes 🞏No |

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| 1. **SPECIFIC QUALIFYING MEDICAL CONDITION INFORMATION** |

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| **CANCER**  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List Chemotherapy, radiation, or other current treatment: |
| **KIDNEY OR LIVER DISEASE**  🞏End stage renal disease  Name of Dialysis Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dialysis Treatment start date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dialysis Day(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏Chronic Kidney Disease  Stage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of labs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Creatinine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ eGFR: \_\_\_\_\_\_\_\_\_\_\_ Hgb: \_\_\_\_\_\_\_\_ Phosphorus: \_\_\_\_\_\_\_\_\_\_\_\_\_  Potassium: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bun: \_\_\_\_\_\_\_\_\_\_\_\_ Alb: \_\_\_\_\_\_\_\_\_  🞏Liver cirrhosis  Severity;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏Hepatitis C |
| **LUNG DISEASE**  🞏COPD 🞏Asthma 🞏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Oxygen assistance? 🞏Yes 🞏No If yes, is 24-hour assistance required? 🞏Yes 🞏No  Other information regarding severity;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HEART DISEASE**  🞏Congestive Heart Failure  ICD-10 code\_\_\_\_\_\_\_ NY Class (if known)\_\_\_\_\_\_\_ Ejection fraction:\_\_\_\_\_\_ Date of labs\_\_\_\_\_\_\_  Describe severity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏Stroke  Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe severity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏Heart Attack  Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe severity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DIABETES**  🞏Type 1 🞏Type 2 🞏Controlled 🞏Uncontrolled  A1c:\_\_\_\_\_\_\_\_\_\_\_\_ Blood glucose:\_\_\_\_\_\_\_\_ Date of labs:\_\_\_\_\_\_\_\_ On Insulin? Yes No  Other known effects on health (e.g., sight or use of limbs)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **NEUROLOGICAL CONDITIONS**  🞏Alzheimer’s 🞏Dementia 🞏Neuropathy 🞏MS 🞏Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe severity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MUSCULAR-SKELETAL CONDITIONS**  🞏Parkinson’s 🞏ALS 🞏Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe severity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HIV AIDS**  🞏HIV Positive 🞏AIDS Viral Load\_\_\_\_\_\_\_\_\_\_\_\_ CD4\_\_\_\_\_\_\_\_\_\_\_ Date of Labs\_\_\_\_\_\_\_\_\_\_\_  On medication and medically adherent? 🞏Yes 🞏No  Effects on current health and well-being? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MENTAL HEALTH**  🞏Depression 🞏Bipolar 🞏Schizophrenia Date of diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe severity of condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **OTHER CONDITION(s) not listed above** |
| Is there anything else we should know about this patient’s medical condition or situation to help us in evaluating the patient for service? |

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| 1. **DOCTOR’S SIGNATURE VERIFICATION** |

|  |  |  |  |
| --- | --- | --- | --- |
| Provider’s Name: | | Signature: | |
| Medical Office: | | | |
| Phone: | Fax: | | Email: |

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| 1. **DOCUMENTS NEEDED** |

Please provide one from each of the following categories:

1. Identification

Driver’s License, passport, government identification

2. Proof of Income

Please submit one of these documents, dated from within the last six months, showing monthly earnings:

* Social Security Administration award or other government benefits letter;
* Proof of Alimony or child support payments;
* Proof of pensions or retirement;
* Unemployment, disability;
* Bank statement showing deposits; or
* Check stub or W-2 form.

3. Prescription Information

* Copy or screenshot of current medications with cost
* Medical Summary from doctor’s office
* Progress notes listing medications

4. Verification of Chronic Illness – must be current within the last 60 to 90 days

* Medical Summary from doctor’s office
* Billing notice listing illnesses and medications
* Progress notes listing illnesses and medications

If you do not have income, please complete this statement:

I do not currently have wages or public benefits.

I get money for living expenses, including food, from the following:

* 🞏other people
* 🞏work for cash
* 🞏savings

Signature Date