

↓ HEAD OF HOUSEHOLD OR PARENT / GUARDIAN ↓

Name (Last, First, MI)			DOB		Sex: <input type="checkbox"/> F <input type="checkbox"/> M	
Mailing Address / P.O. Box		Apt#	City	State	Zip	
Home Number ( )	Cellular Number ( )	Ethnicity? <input type="checkbox"/> American Indian <input type="checkbox"/> African American <input type="checkbox"/> Latino <input type="checkbox"/> Caucasian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Other: _____			Preferred Language	
Employers Name		Work Number ( )	Household Income: \$ _____ Weekly    \$ _____ Monthly    \$ _____ Yearly			
Email Address (Confidential):		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____			Are you currently Insured?	
Family Emergency Contact Name: (Very Important DO NOT OMIT)			Phone ( )		Are <u>YOU</u> applying for AccessHealth?	
Referred From: <input type="checkbox"/> Friend <input type="checkbox"/> SNHD <input type="checkbox"/> CHC <input type="checkbox"/> Flyer <input type="checkbox"/> 211 <input type="checkbox"/> Ryan White Title II <input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Other: _____						
Number of Individuals living in the Household? _____			Have you visited an Emergency Room within the last 12 months? <input type="checkbox"/> Yes or <input type="checkbox"/> No If so, how many times? _____			

↓ PLEASE LIST ALL THE CHILDREN AND FAMILY MEMBERS WITHIN HOUSEHOLD ↓

Name	D.O.B.	Sex	Name of Child's School	Amount of school days missed last school year due to illness?	Are you currently enrolled with Medicaid, NV Ck-Up or Private Health Insurance?	Number of ER visits in last 12 months?

I attest that the information that I provided to qualify for the AccessHealth program is accurate and true to the best of my knowledge. I acknowledge my responsibility to pay for medical care according to the fees established. I understand that if I have falsified this application, I may be disqualified from the program. By signing below, I allow AccessHealth to verify any and all information submitted.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please submit the completed application utilizing 1 of the 3 below options. Once your application is received and screened by AccessHealth, you may be contacted for further information and/or an AccessHealth Identification card will be mailed to you.

Fax to (702) 430-3586                       Mail to AccessHealth, 2801 S. Valley View Blvd., Suite 12, Las Vegas, NV 89102                       Email to [accesshealth@gbpca.org](mailto:accesshealth@gbpca.org)  
 Stop by our office during the business hours of Monday thru Friday 8:30 am to 5:00 pm. (Closed for Lunch)                      \*For additional applications visit [www.gbpca.org/accesshealth](http://www.gbpca.org/accesshealth)

## Rights and Responsibilities

**AccessHealth is not an insurance carrier.** AccessHealth provides you access to a network of health care providers who offer discounted fees for health care services. AccessHealth is not responsible for the quality of care of the provider network of hospitals, physicians, or other providers. **To receive discounted healthcare all appointments must be coordinated by AccessHealth.**

**As a client of AccessHealth you:**

Have The Right To

- Be treated with respect and dignity by AccessHealth and contracted health care providers.
- Be referred to contracted providers regardless of race, color, sex, national origin, handicap, religion or sexual orientation.
- Change your primary care provider (PCP).
- Discuss your health concerns and questions about diagnosis and treatments with those providing you health care services. Be involved in decisions about your health care.

Have The Responsibility To

- Treat all contracted health care providers and AccessHealth staff with respect and dignity.
- You must show your AccessHealth I.D. card to providers before you receive any care or services.
- Make payments to health care providers at time of service unless payment plans are arranged.
- Inform AccessHealth and your health care provider(s) of any changes in your health care coverage, income, employment status, change of address and phone number.
- Please call your health care professional in advance (at least 24 hours) if you wish to cancel or change your appointment and be sure to take your referral with you.
- Contact your AccessHealth case worker for all appointments and additional procedures recommended to be performed during or after office visits with providers for options of other discounted providers.

*\* Any non-compliance of any patient responsibilities (such as no shows to appointments or non-payment of provider services) can lead to dis-enrollment in the AccessHealth Program.*

The privacy of a client's protected health information will be maintained as required by law by AccessHealth and contracted network providers. The information to be shared between contracted providers and AccessHealth will include: demographic information such as name, address and age, and related health care services coordinated by AccessHealth.

AccessHealth is a non-profit program. Contracted network providers (covered entities) will use appropriate safeguards to prevent use or disclosure of Protected Health Information in compliance with Covered Entities Notice of Privacy Practices. A client has the right to receive applicable Notice of Privacy Practices information. The Notice of Privacy Practices is available from Covered Entities (AccessHealth contracted network providers). For a complete description of the Notice of Privacy Practices for Protected Health Information [45 CFR 164.250] you can access this information by making a request from AccessHealth at [accesshealth@gbpca.org](mailto:accesshealth@gbpca.org).

By signing below, I authorize AccessHealth, and its authorized employees, agents, independent contractors, and participating providers to release to and/or obtain from, physician, practitioner, hospital, clinic or medically related facility my utilization of health care services information from AccessHealth network providers.

I attest that the information that I provided to qualify for AccessHealth is accurate and true to the best of my knowledge. I acknowledge my responsibility to pay for medical care according to the fees established. I understand that if I have falsified this application, I may be disqualified from the program. By signing below, I also acknowledge that I will comply with the Client Rights and Responsibilities.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

<b>AH Staff Init.</b>	<b>Head of Household Client #</b>	<b>Site</b>	<b>PCP Provider/s</b>
-----------------------	-----------------------------------	-------------	-----------------------

**Resources for the AccessHealth Clark County School District Expansion Project Provided by the Lincy Foundation.**

2801 S. Valley View Blvd., Suite 12 - Las Vegas, NV 89102 - Telephone (702)-430-3580 Fax (702) 430-3586