



**Enter information about the children (younger than 19) in the home.**

Questions	Child 1	Child 2	Child 3
<b>1. Child's name</b>	First _____ MI _____ Last _____	First _____ MI _____ Last _____	First _____ MI _____ Last _____
<b>2. Birth Date</b>	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
<b>3. Social Security #</b>	_____	_____	_____
<b>4. Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>5. Marital Status</b>	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed Spouses Name: _____	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed Spouses Name: _____	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed Spouses Name: _____
<b>6. Race</b>	<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____
<b>7. Is this person a resident of Maricopa County?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>8. Place of Birth</b>	<input type="checkbox"/> U.S.A. <input type="checkbox"/> Other Country _____	<input type="checkbox"/> U.S.A. <input type="checkbox"/> Other Country _____	<input type="checkbox"/> U.S.A. <input type="checkbox"/> Other Country _____
<b>9. U.S. Citizenship or Non-Citizen Status</b>	<input type="checkbox"/> Yes, a U.S. Citizen <input type="checkbox"/> No, not a U.S. Citizen Immigration I.D. # A _____	<input type="checkbox"/> Yes, a U.S. Citizen <input type="checkbox"/> No, not a U.S. Citizen Immigration I.D. # A _____	<input type="checkbox"/> Yes, a U.S. Citizen <input type="checkbox"/> No, not a U.S. Citizen Immigration I.D. # A _____
<b>10. Does this person have Health Insurance?</b>	<input type="checkbox"/> Yes Insurance _____ Phone number _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes Insurance _____ Phone number _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes Insurance _____ Phone number _____ <input type="checkbox"/> No
<b>11. Does this child receive child support?</b>	<input type="checkbox"/> Yes, Amount: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes, Amount: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes, Amount: _____ <input type="checkbox"/> No
<b>12. Name of parent(s) or guardian living at home with the child</b>	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Step-mother _____ <input type="checkbox"/> Step-father _____ <input type="checkbox"/> Other Relative _____ Relationship _____	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Step-mother _____ <input type="checkbox"/> Step-father _____ <input type="checkbox"/> Other Relative _____ Relationship _____	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Step-mother _____ <input type="checkbox"/> Step-father _____ <input type="checkbox"/> Other Relative _____ Relationship _____

**Is anyone listed on this application self-employed?**

Yes Enter the self-employed person's name: \_\_\_\_\_

How much is the average gross monthly income? \_\_\_\_\_ Average monthly expenses? \_\_\_\_\_

No

**Please fill in all information about any other income of all of the persons listed on this application.**

Name of person receiving income	Type of income	Name and address of employer, agency or person who provides income	Telephone number of employer	How often paid? (weekly, biweekly, monthly)	Gross amount (before deductions) received each time	Hours worked per week	Hourly rate	Overtime hours worked per week	Overtime hourly rate

**Does anyone listed on this application expect a change in income during the next 6 months?**

Yes

No

If you checked YES, explain WHO, WHEN and HOW MUCH it will change the amount of income received

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## Member Rights And Responsibilities

### **You Have The Right To:**

- Be treated with respect and dignity by HealthCare Connect staff and health care providers.
- Get the services available to you through HealthCare Connect regardless of race, color, sex, national origin, or handicap.
- Change your primary care provider (PCP). You must notify HealthCare Connect of the change.
- Discuss your health concerns with those providing you health care services.
- Ask questions about and get information on diagnosis, treatments and expect treatment results, and be involved in decisions about your health care.

### **You Have The Responsibility To:**

- Treat all HealthCare Connect staff and health care providers with respect and dignity.
- Protect your ID card. You must show your HealthCare Connect card to your PCP, Specialist, Hospital and other providers before you get any care or services.
- Make payments to PCP, Specialist, Hospitals and other providers at time of service.
  1. Fees at participating primary care clinics may vary. Contact your PCP's office directly for rates.
  2. Specialist's fees are \$25.00 for consultation services, additional procedures or tests are discounted based on established rates.
  3. Hospitalization rates are \$400.00 - \$600.00 per day with a limit of \$2000.00 per admission. (Rates include the facility only. You may incur additional costs such as physician charges.)
- Immediately inform HealthCare Connect, your PCP, and your specialty care providers of any changes in your health care coverage, income, employee status, **including 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. **A \$25.00 co-payment will be charged to you for no shows.**
- **Failure to comply with the responsibilities above will result in your disenrollment with HealthCare Connect.**

HealthCare Connect is not responsible for the quality of care or services received by its member from network hospitals, physicians, and other providers. Members are not required to use the HCC provider network, expect to receive discounts.

I authorize HealthCare Connect and its authorized employees, agents, independent contractors, and participating providers to release to and/or obtain from, said physician, practitioner, hospital, clinic, other medical or medically related facility my enrollment and medical record information.

\_\_\_\_\_  
Signature of applicant, responsible adult, or authorized representative

\_\_\_\_\_  
Date

### **Before you send this application, please check the following:**

- I answered all questions on the application that apply to household.
- I put my phone number and mailing address on the application.
- I attached or faxed proof of residency. (Such as utility bill, phone bill, etc.)
- I attached or faxed proof of income. (Pay stubs for the last 30 days)
- I signed the application.
- If you have any questions please contact HealthCare Connect at (602) 288-7564.