

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

Questions	Child 1	Child 2	Child 3
1. Child's name	First MI Last	First MI Last	First MI Last
2. Birth Date	____/____/____	____/____/____	____/____/____
3. Social Security #			
4. Sex			
5. Marital Status	Spouses Name:	Spouses Name:	Spouses Name:
6. Race			
7. Place of Birth	State _____.	State _____.	State _____.
8. U.S. Citizenship or Non-Citizen Status	Immigration I.D. # A _____ Date of entry _____	Immigration I.D. # A _____ Date of entry _____	Immigration I.D. # A _____ Date of entry _____
9. Does this person have Health Insurance?	Phone number _____	Phone number _____	Phone number _____
10. Does this child receive child support?			
11. Name of parent(s) or guardian living at home with the child	Relationship	Relationship	Relationship
12. Determined blind or disabled by SSA or VA?			

Is anyone listed on this application self-employed?

How much is the average gross monthly income? _____ Average monthly expenses? _____

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?

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

Has anyone on this application incurred any hospital expenses in the last 60 days?

Does anyone on this application have any care expenses? (child care, child support, dependent care, etc.)

Name of person billed for care expense(s)	Person(s) cared for	Type of care expense(s)	Frequency (weekly, biweekly, monthly)	Amount Paid

What are the total monthly housing and utility expenses for the household? (please complete this page if interested in applying for food stamps or cash assistance)

Housing	Utilities
Rent: _____	Electricity: _____
Mortgage: _____	Gas or propane: _____
Taxes: _____	Coal, oil or wood: _____
Insurance: _____	Garbage, sewer, septic: _____
Homeowners fees: _____	Water: _____
Other: _____	Telephone: _____
	Other: _____

Does anyone on this application own a home in Arizona?

Does anyone in this application own other houses, land, mobile homes outside Arizona?

Does anyone in this application own vehicle(s)? (car, truck, motorcycle, rv's, boats or campers)

Does anyone listed on this application have a savings or checking account?

Does anyone listed on this application have an IRA, KEOGH, deferred compensation, retirement or annuity account?

Does anyone listed on this application have cash or uncashed checks not including regular pay checks?

Does anyone listed on this application have stocks, bonds, certificates of deposit, money market or mutual funds?

Member Rights And Responsibilities

You Have The Right To:

- Be treated with respect and dignity by HealthCare Connect staff and participating 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 (Limit 2 times per year).
- Discuss your health concerns with those providing you health care services.
- Ask questions about and get information on diagnosis, treatments and expected treatment results, and be involved in decisions about your health care.

You Have The Responsibility To:

- Treat all HealthCare Connect staff and participating 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 \$50.00 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 maximum 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.**
- Members pay a **non-refundable** annual enrollment fee of \$50.00 for singles or \$100.00 for families of two or more.
- **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, except 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

By signing as a sponsor for the above applicant, I understand that I am accepting full financial responsibility for the applicant's enrollment fees and for payment to the health care providers for any health care service received by the above named applicant.

Signature of Sponsor

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.