Health Care District
PALM BEACH COUNTY

HCD USE ONLY	
Member #:	
Site:	
Analyst:	
❑ **New** ❑ **Renewal**	

Please read the attached Information sheet and answer ALL questions. Application must be signed in section 7.

PART 1 HEAD OF FAMILY INFORMATION

HEAD OF FAMILY (Person who will receive the mail)

Last Name: First Name: M.I.

Address where you live: Apt. #:

City: FL Zip Code:

Address where you receive mail:
(If different from where you live): Apt. #:

City: FL Zip Code:

Employer: Job Title:

Employer Address:

Cell Phone:
Home Phone:
Work Phone:
Email:

Are you ❑ married ❑ single ❑ divorced ❑ widowed ❑ separated

PART 2: FAMILY INFORMATION

List your name and the name of each person in your family, who lives in your house even if they have other medical coverage. All columns must be completed. Don't forget to include yourself in the shaded portion of this section.

Legal Name Last, First, Middle Initial	**Date of Birth**	**Sex M / F**	**Relationship to you**	**Social Security Number**	**Race B/W/H/O**	**Country of Birth**	**U.S. Citizen (Y/N)**	**Want to apply for Medical coverage? (Y/N)**
			Yourself					

PART 3: OTHER INFORMATION

Have you lived in Palm Beach County for the past 6 months? ❑ Yes ❑ No

If you have not lived in Palm Beach County for the past 6 months, do you plan to stay in Palm Beach County? ❑ Yes ❑ No

Is any person on this application pregnant? ❑ Yes ❑ No If yes, who?_____ Due date: _____

Is anyone on this application receiving Disability benefits? ❑ Yes ❑ No If yes, who? _____
Is the Disability benefit from Medicaid or the Social Security Administration? ❑ Yes ❑ No

Are you or anyone in your house a U.S. Veteran? ❑Yes ❑No If yes, who? _____

Does anyone in your family have VA medical coverage? ❑ Yes ❑ No If yes, who? _____

Do you or anyone in your house have health insurance? ❑ Yes ❑ No If yes, who? _____
Name of insurance company: _____

Do you or anyone in your house have Medicare? ❑ Yes ❑ No If yes, who? _____

Do you or anyone in your house have Medicaid or Medically Needy/Share of Cost? ❑ Yes ❑ No If yes, who? _____

Are you or anyone else in your family waiting for a decision about a lawsuit for an auto or work related injury? ❑Yes ❑ No
If yes, who? _____ Attorney's Name:_____ Phone:_____

PART 4: FAMILY INCOME INFORMATION

List all income received by adults and children listed on this application. Be sure to show the amount of income before deductions (gross income). Use an extra sheet if needed. (Write in the monthly amount for each kind of income).

Name of Person Receiving Income	Monthly Gross	Type of Income	Check all boxes that apply:
	$		❑AFDC ❑ Alimony ❑Annuity ❑Child support ❑Contributions/Support ❑Loans❑Pensions ❑Rental Income ❑Self-employment income ❑Social Security/SSI ❑Trust fund ❑Unemployment ❑Veterans benefits ❑ Wages ❑Worker's compensation
	$		
	$		

HCD Use Only:	TOTAL Monthly Family Income (Add all totals) ➔	
	FPLG % ➔	

PART 5: ALLOWABLE DEDUCTION INFORMATION

Are you making any payments for ❑ health insurance premiums ❑ life insurance premiums ❑ child support ❑ alimony ❑ medical payments? How much is paid each month? $_____

PART 6: FAMILY EXPENSES

List how much is paid each month:

Rent/Mortgage:	$	Car Payment:	$
Utilities (electric/water/phone):	$	Insurance: ❑ Auto ❑ Life	$
Transportation (gas, bus, etc):	$	Loans:	$
Child Care:	$	Medical Expenses:	$
Credit Cards:	$	Other:	$
Food:	$	**TOTAL:**	$

Is anyone helping you pay your bills? ❑ Yes ❑ No If yes, who? _____

PART 7: CERTIFICATION AND AUTHORIZATION INFORMATION

I am applying for services and I certify that all of the information and documentation provided to the Health Care District of Palm Beach County ("District") is true, correct and complete. I also certify that the individuals applying for medical coverage have no other insurance coverage. If I am entitled to any action against or settlement from third party payers, I will notify the District immediately. I authorize the District to check my credit history or income through a credit bureau or verification agency, if deemed appropriate. I authorize the release of all personal, financial, and medical information to the District for determining eligibility for services and for research. I understand all information is subject to audit. I understand that I am obligated to pay the District back for all monies paid on my behalf. This includes monies paid to me from any other source, if such payments were based upon false or incorrect information provided. I understand that I shall be responsible for the cost of recovering such amounts, including reasonable attorney's fees and costs at all levels of trial and appeal. I understand that the District's participating specialty providers and local Health Centers are independent contractors and are not agents or employees of the District. I agree that all services, in order to be covered by the District, must be performed by a participating provider and that a referral may be required. I authorize any doctor, hospital or other health care provider to furnish the District (or its assignee or designee) with medical information as the District (or its assignee or designee) may require, and that my medical information may be shared with the CL Brumback Primary Care Clinics. I agree not to let any other person use my membership card for any reason or purpose. It is the policy of the District that progressive remedial action up to and including termination of individuals and/or entire family units from assigned District health coverage programs will occur if evidence of (not limited to) members providing false information on the application, if the member displays inappropriate behavior, and compliance and conduct issues as documented in ELG-5000.18. For a copy of this policy, please contact Customer Service at (561-642-1000)

SIGNATURE IS REQUIRED BELOW FOR ALL ADULTS OVER THE AGE OF 18 LISTED IN SECTION 2: FAMILY INFORMATION

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

(Legal guardian may complete this form when the patient is not alert or competent)

What language do you speak or read? ❑ English ❑ Spanish ❑ Creole

Please fax completed application with attachments to 561-804-4229

Visit our website at www.hcdpbc.org

Health Care District Use Only

Case Worker:_____ Date_____

Approved ❑ Denied ❑ Denial Reason: _____

District Cares Attestation Workflow

The Health Care District of Palm Beach County administers the District Cares program for eligible, uninsured residents of Palm Beach County. The program is available to individuals and/or families who do not qualify for any other public assistance health coverage program and who meet income and residency requirements. The District Cares program offers members access to the C. L. Brumback Primary Care and Dental Clinics, Federally Qualified Health Centers owned and operated by the Health Care District of Palm Beach County. Trauma patients at either St. Mary's Hospital or Delray Medical can also qualify for the District Cares program.

Program Guidelines

When applying for the District Cares program, information documenting proof of residency, income and identification are required. Eligibility representatives are available to offer assistance in fulfilling the documentation requirements. At the Trauma hospital this should be completed by case worker. At the CL Brumback Primary Care Clinics this will be completed by the certified application counselor.

Residents who are potentially eligible for Medicaid should apply and receive a denial before submitting an application for the District Cares program. Residents who receive Medicare parts A and B benefit are not eligible for District Cares. Medicare recipients who are in need of prescription drug benefits should apply for Medicare Part D.

Being Considered

1. C.L. Brumback Primary Care Clinics (CLBPCC) or Trauma patients (St. Mary's Hospital or Delray Medical Center) in Palm Beach County are the only way to access the District Cares Voucher Program.
    a. Be a resident of Palm Beach County
    b. See a Primary Care Provider at CLBPCC or be a Trauma patient at one of the hospitals above.
    c. Complete the District Cares attestation.
    d. Certified Application Counselor will review and approve eligibility.

Instructions to Complete the Attestation Process

You will be asked questions by the CAC or Trauma Hospital eligibility team, and need to provide responses to all or it will delay the approval process. Only send copies of information, do not send originals.

Requirement Sections

Part 1. Head of Family Information

Proof of Palm Beach County residence and plan to stay in Palm Beach County. Include only **ONE (1)** of the following papers:

a. A property tax bill or any information that shows ownership of property in Palm Beach County
b. A copy of a Voter Registration Card
c. A copy of a current lease or rent receipt that shows who the owner is and a way to contact them

d. A mortgage statement
e. A current Florida driver's license or vehicle registration that shows the same address that is on the application
f. A current electric, phone, water, TV cable or any other utility bill that shows service at the same address that is on the application
g. Palm Beach County school registration certificate of a member on the application
h. A letter from an agency (social, religious, fraternal etc.) in Palm Beach County that shows a person in the family is enrolled.
i. A Declaration of Domicile that has been filed at the courthouse.

Part 2. Family Information

This section addresses the size of the family and which family members are looking for health care coverage. You should include all minor children (under age 18) that are living in the household. Be sure to send in the two (2) forms of identification for everyone applying for health care coverage. **Do not** include grandparents, aunts, uncles, cousins, nieces, nephews. They should complete a separate application.

The identification that is needed is a copy of **any two (2)** items listed below for each person in the family. **Remember that a picture ID and a signed copy of the Social Security Card are the best kind of ID to send.**

a. A Social Security Card or validated number
b. US Certificate of Naturalization
c. Any birth certificate (Any state or country) or registration card
d. A letter or identification from any law enforcement person
e. Any official passport
f. Any Alien registration card
g. School identification
h. Any military identification card
i. Church or Temple membership
j. Medical Records
k. Any Drivers license, any state, country or international

Part 3. Other Needed Information

This information assists with determining the best health coverage for the patient.

Part 4. Family Income information

Last four (4) weeks of the money earned (before deductions) to determine eligibility for health coverage. All money received from anyplace listed below is counted.

a. AFDC
b. Alimony
c. Annuity

d. Child Support
e. Contributions/Support
f. Loans
g. Pensions
h. Rental Income
i. Unemployment
j. Veterans
k. Wages/Paystubs
l. Worker's Compensation

Part 5. Allowable Income Deduction Information

Monthly payments for the following: alimony; child support; health insurance premiums; life insurance premiums; and/or medical payments.

Part 6. Family Expenses

Monthly family expenses. If nothing is paid, put a zero (0) in each box.

Process for CLB Primary Care Clinic CAC

1. After reviewing documents provided and questions answered by the patient. The CAC may ask for additional clarification. If nothing else is needed the CAC can approve for six months or deny District Cares Voucher program.
2. A Health Access letter will be sent to the patient with eligibility dates.
3. Patient will need to follow program guidelines and cannot see a specialist outside of the CL Brumback Primary Care Clinic or Trauma hospital without authorization.