SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

# Patient Enrollment Application

Thank you for your interest in the MedAssist program. Please complete the enclosed application and return it to MedAssist along with the required documents.

Upon receipt of your completed application, MedAssist staff will determine if you are eligible for financial assistance based on our program guidelines and subject to available funding. Please understand that all approvals are based on available funding and are on a first-come-first-served basis.

**Please send complete application packet to:**

**Fax:** (408) 885-4093

**Mail:** Attn: MedAssist
777 Turner Dr, Suite 330
San Jose, CA 95128

**Drop off:** Any Santa Clara Valley Medical Center Outpatient Pharmacy

**VALLEY HEALTH CENTER BASCOM**
750 S. Bascom Avenue
San Jose, CA 95128
(408) 885-2320

**VALLEY HEALTH CENTER GILROY**
7475 Camino Arroyo
Gilroy, CA 95020
(408) 852-2212

**VALLEY HEALTH CENTER MOORPARK**
2400 Moorpark Ave
San Jose, CA 95128
(408) 885-7675

**VALLEY HEALTH CENTER DOWNTOWN**
777 E. Santa Clara Street
San Jose, CA 95112
(408) 977-4500

**VALLEY HEALTH CENTER LENZEN**
976 Lenzen Ave,
San Jose, CA 95126
(408) 792-5170

**VALLEY HEALTH CENTER SUNNYVALE**
660 S. Fair Oaks Avenue
Sunnyvale, CA 94086
(408) 992-4830

**VALLEY HEALTH CENTER EAST VALLEY**
1993 McKee Road
San Jose, CA 95116
(408) 254-6340

**VALLEY HEALTH CENTER MILPITAS**
143 North Main Street
Milpitas, CA 95035
(408) 957-0919

**VALLEY HEALTH CENTER TULLY**
500 Tully Road
San Jose, CA 95111
(408) 817-1360

**VALLEY SPECIALTY CENTER**
751 S. Bascom Ave
San Jose, CA 95128
(408) 885-2310

**O'CONNOR OUTPATIENT PHARMACY**
2101 Forest Ave
San Jose, CA 95128
(408) 947-2988

**Please contact us if you have any questions or need assistance filling out the application form.**

**Phone:** (408) 970-2001
**Email:** medassist@hhs.sccgov.org
**Hours:** Monday – Friday, 9AM – 5PM
https://scvmc.org/medassist

**Getting Started**

**What Information Do I Need?**

1. Patient contact and demographic information
2. Prescription information
    a. Medication name
    b. Copy of prescription **OR** pharmacy information
3. Financial information
    a. Estimate of annual gross household income and household size
    b. Estimate of out-of-pocket healthcare expenses from previous calendar (January 2020 – December 2020)

As part of your application, you will need to attest to the amount of out-of-pocket healthcare expenses you had in the previous calendar year. Out-of-pocket healthcare expenses include:

- Medical and prescription co-payments
- Insurance premiums

**What Documents do I Need?**

Proof of Residence in Santa Clara County – Provide **ONE** of the following:

- Current Rental Contract/Lease
- Current Mortgage Statement
- Current Utility Bill (Water, Electric, Gas, Garbage)
- Homeless (Completion of patient statement form)
- Vehicle Registration
- Driver License (Current)
- Letter of support from person with whom applicant is living with and proof of residency for that person

Proof of Identity (Photo ID Required) – Provide **ONE** of the following:

- Valid Driver's License
- Valid Passport
- Valid Government issued ID Card
- Valid Work or School ID Card
- Birth Certificate along with any valid photo identification

Proof of Income – Provide **ALL** that apply **for your entire household:**

- Current Check Stubs (all stubs not older than 45 days from application date)
- Recent Tax Return (recent tax year)
- Award Letter (Social Security, Disability, Unemployment, Worker's Compensation)
- Current Cash Income Statements (including tips)
- Current Military Benefits Statement
- Current Rental Income Receipts

Proof of valid prescription(s) – Provide ONE of the following for each qualifying prescription:

- Copy of Prescription
- Pharmacy Contact Information

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Staff Use Only: Date: _____ Time: _____

## Section 1: Patient Information

| | | |
|---|---|---|
| Legal Name (Last, First, Middle):* | | |
| Patient DOB (MM/DD/YY):* | | Preferred Language:* |
| Address:* | | |
| City:* | State: CALIFORNIA | Zip Code:* |
| Home Phone Number:* ( ) - | | Mobile Phone Number: ( ) - |
| Email Address: | | |

Gender Identity:*

| | | |
|---|---|---|
| ▫ Male | ▫ Transgender Female | ▫ Non-binary |
| ▫ Female | ▫ Transgender Male | ▫ Other |

| Ethnicity:* | | Race:* | |
|---|---|---|---|
| ▫ Not Hispanic or Latino | ▫ Latin American | ▫ Patient Declined / Unable to Specify | ▫ White, North American |
| Spaniard | ▫ Puerto Rican | ▫ Asian, Filipino | ▫ White, European |
| ▫ Mexican | ▫ Cuban | ▫ Asian, Vietnamese | ▫ White, Middle Eastern or North African |
| ▫ Central American | ▫ Dominican | ▫ White, Arab | ▫ Black, African American |
| ▫ South American | ▫ Other Hispanic or Latino | ▫ Hispanic or Latino | ▫ White, Other |
| | ▫ Decline/Unable to specify | ▫ Asian, Chinese | ▫ Native American |
| | | ▫ Asian, Laotian | ▫ Alaska Native |
| | | ▫ Asian, Korean | ▫ Asian, Other |
| | | ▫ Asian, Cambodian | ▫ Pacific Islander, Guamanian |
| | | ▫ Asian, Japanese | ▫ Pacific Islander, Samoan |
| | | ▫ Asian, Indian | ▫ Pacific Islander, Hawaiian |
| | | ▫ Asian, Pakistani | |
| | | ▫ Black, African | |
| | | ▫ Black, Other | |

How Did You Hear About the MedAssist Program?*

| | | |
|---|---|---|
| ▫ Friend or Family | ▫ SCVMC Website | ▫ Newspaper |
| ▫ Financial Assistance Counselor | ▫ Instagram | ▫ NextDoor |
| ▫ Doctor's Office | ▫ Facebook | ▫ Other (please specify): |
| ▫ Pharmacy | ▫ LinkedIn | _____ |

**Section 2: Prescription Information**

Please list each of your current prescriptions from the following three (3) medication categories:

- Insulin
- Asthma inhaler
- Epinephrine auto-injector

| **Prescription 1:** | | |
|---|---|---|
| Medication Name:* | | |
| Medication Category: [select one]*<br>☐ Insulin<br>☐ Asthma inhaler<br>☐ Epinephrine auto-injector | | |
| *If you are not attaching a hardcopy prescription with this application, please fill out the section below:* | | |
| Pharmacy Information: | | |
| Pharmacy Name: | Pharmacy Phone Number:<br>(  )  - | |
| Address: | | |
| City: | State: | Zip Code: |

| **Prescription 2:** | | |
|---|---|---|
| Medication Name:* | | |
| Medication Category: [select one]*<br>☐ Insulin<br>☐ Asthma inhaler<br>☐ Epinephrine auto-injector | | |
| *If you are not attaching a hardcopy prescription with this application, please fill out the section below:* | | |
| Pharmacy Information: | | |
| Pharmacy Name: | Pharmacy Phone Number:<br>(  )  - | |
| Address: | | |
| City: | State: | Zip Code: |

| **Prescription 3:** | | |
|---|---|---|
| Medication Name:* | | |
| Medication Category: [select one]*<br>☐ Insulin<br>☐ Asthma inhaler<br>☐ Epinephrine auto-injector | | |
| *If you are not attaching a hardcopy prescription with this application, please fill out the section below:* | | |
| Pharmacy Information: | | |
| Pharmacy Name: | Pharmacy Phone Number:<br>(  )  - | |
| Address: | | |
| City: | State: | Zip Code: |

| **Prescription 4:** | | |
|---|---|---|
| Medication Name:* | | |
| Medication Category: [select one]*<br>☐ Insulin<br>☐ Asthma inhaler<br>☐ Epinephrine auto-injector | | |
| *If you are not attaching a hardcopy prescription with this application, please fill out the section below:* | | |
| Pharmacy Information: | | |
| Pharmacy Name: | Pharmacy Phone Number:<br>(  )  - | |
| Address: | | |
| City: | State: | Zip Code: |

| **Prescription 5:** | | |
|---|---|---|
| Medication Name:* | | |
| Medication Category: [select one]*<br>☐ Insulin<br>☐ Asthma inhaler<br>☐ Epinephrine auto-injector | | |
| *If you are not attaching a hardcopy prescription with this application, please fill out the section below:* | | |
| Pharmacy Information: | | |
| Pharmacy Name: | Pharmacy Phone Number:<br>(  )  - | |
| Address: | | |
| City: | State: | Zip Code: |

| **Prescription 6:** | | |
|---|---|---|
| Medication Name:* | | |
| Medication Category: [select one]*<br>☐ Insulin<br>☐ Asthma inhaler<br>☐ Epinephrine auto-injector | | |
| *If you are not attaching a hardcopy prescription with this application, please fill out the section below:* | | |
| Pharmacy Information: | | |
| Pharmacy Name: | Pharmacy Phone Number:<br>(  )  - | |
| Address: | | |
| City: | State: | Zip Code: |

**Section 3: Financial Information**

| # People living in your household:<br>(include yourself, spouse/partner,<br>all adults):* | # Dependents:<br>(under 18 years of age):* |
|---|---|
| Income Information | |
| Total Annual Household Income Gross (Combined from all sources):*<br><br>$ | |
| Annual Healthcare Expenses | |
| Household Healthcare Out-of-Pocket Expenses in the previous calendar year (January 2020 – December 2020) – *this includes your Medical and Prescription Co-payments, Insurance Premiums** <br><br>$ | |

COUNTY OF SANTA CLARA
Health System

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**1**
Patient Name:_____
Date of Birth:_____
ID or Medical Record #_____
Address:_____
_____
Tel:_____

**2** **AUTHORIZATION:** I give permission to My Pharmacy to use and release to
Recipient Name:SCVMC Pharmacy Department
Address:777 Turner Drive, Suite 330 San Jose, CA 95128
Phone:408-885-2300 Fax:408-885-5822

**3** **PURPOSE:** The health information disclosed may only be used for the following purpose(s):My enrollment and participation in the MedAssist Program.

**4** **INFORMATION TO BE RELEASED**

A. ☐ **Medical Record**
- ☐ All health information (e.g. diagnosis, test results, treatment); OR
- ☐ Images and/or Films ☐ Reports ☐ Billing ☐ Dental

B. ☐ **HIV/AIDS Test Results** (A separate authorization is required for each disclosure.) **Initial**: ___

C. ☐ **Drug & Alcohol Treatment**(e.g. diagnosis, test results, treatment, billing, attendance) **Initial**:___

D. ☐ **Mental Health** (e.g. diagnosis, test results, treatment, billing) **Initial**:___

E. ▣ **Other**My prescription, billing information, and fill history for insulin, asthma inhaler, **Initial**:___

**5** **DELIVERY PREFERENCE:**
▣ Mail ☐ Pick up ▣ OtherPhone, Fax, Emai

**6** **DELIVERY FORMAT:**
☐ CD ☐ Film ▣ Paper ▣ OtherElectro

**7** **DURATION:** This authorization is valid immediately and will be valid until_____(*give date*). If I do not write in a date, it will expire twelve months from the date it was signed.

**8** **CANCELLATION**: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department, 751 S. Bascom Ave., San Jose, CA 95128 and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by CSCHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5328. Call: 408-885-5770.

**9** **CONDITIONS:** I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.
A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

**10** **REDISCLOSURE:** Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

**11** _____ _____ _____ _____
Patient/Patient's Representative Name Patient/Patient's Representative Signature Relationship Date

COUNTY OF SANTA CLARA
Health System

**NOTICE OF PRIVACY PRACTICES**

## *ACKNOWLEDGEMENT OF RECEIPT*

By signing this form, you acknowledge you have received a copy of our ***Notice of Privacy Practices.*** Our ***Notice of Privacy Practices*** gives you information about how we may use and disclose your medical or protected health information (PHI). Please read it carefully.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, we will post the revised version in our facilities. You may obtain a copy of the latest ***Notice of Privacy Practices*** from our Registration or Admitting staff when you come to any of our facilities for services or treatment.

I hereby acknowledge receipt of the ***Notice of Privacy Practices*** of County of Santa Clara Health System (CSCHS).

Date: _____ Signature: _____
(patient/parent/conservator/guardian)

Name: _____
(please print)

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***INABILITY TO OBTAIN ACKNOWLEDGEMENT***

*This portion must be completed only if no signature can be obtained. If it is not possible to obtain the individual's acknowledgement, describe good faith efforts made to obtain the acknowledgement, and the reasons why the acknowledgement could not be obtained.*

_____
_____
_____
_____
_____
_____
_____

Date: _____ Signature: _____
(Representative of CSCHS)

Title: _____

**Terms and Conditions of Program Participation**

1. Patient has applied, or has granted permission for a representative to apply on Patient's behalf, to participate in the MedAssist program. If the patient meets eligibility criteria based on information provided in the application and funds are available, the Patient will be awarded a grant to assist with out-of-pocket healthcare expenses such as copayments, coinsurance, deductibles, and/or insurance premiums.
2. Patient understands that any false or information provided on the MedAssist application could lead to revocation of the Grant at any time and furthermore may constitute fraud for which the Patient may be legally liable.
3. If MedAssist becomes aware of any inaccurate information or fraudulent activity relating to the Patient's application and the application is approved, participation in the program will terminate and MedAssist may recoup the amount of financial assistance provided to the Patient.
4. Patient authorizes SCVHHS to request a credit report and/or to verify any of the information provided in the application as deemed necessary.
5. MedAssist has the right at any time, without notice to Patient, to modify or discontinue all or any part of the MedAssist program and/or Grant.
6. Patient is not guaranteed or promised financial assistance, and that any assistance provided by MedAssist is limited to the terms and conditions established by MedAssist.
7. Patient agrees to notify MedAssist if any of the following information has changed:
    a. Personal information: home address, phone number, E-mail address, contact information
    b. Household information: had another child or adopted a child, child moves in or out of the home, death in the family, got married, getting divorced, legally separated, have a registered domestic partner
    c. Job status: became unemployed, salary changed, got an extra job, spouse employment or salary changed
    d. Income: income changes, investments or assets change, got an inheritance or pension, bought or sold property

□ I have read and agree to fully comply with the Terms and Conditions of Program Participation. I understand that failing to do so may lead to termination of my participation in the MedAssist program.

I certify under penalty of perjury by my signature that the information I have provided as required in this agreement is true and complete to the best of my knowledge and belief.

_____ _____

Patient/Patient's Representative Name Patient/Patient's Representative Signature

_____ _____

Relationship to Patient Date