JPS HEALTH NETWORK

Dear Applicant:

Welcome to JPS Health Network. We look forward to providing affordable health care to you and your family. The purpose of the JPS Connection program is to create a healthier community by providing discount health services to Tarrant County residents. Connection cardholders have the benefit of a medical home – meaning you have a physician or nurse practitioner assigned to you and your family. You get access to preventative care – such as physicals and screenings that will help keep you healthy and out of the emergency room.

Inside this packet you will find the application and the documentation requirements for our JPS Connection program. Please complete the enclosed application and submit it along with supporting documentation. You may call our Eligibility Center at (817) 702-1001 should you need assistance, our staff members are happy to answer any questions you may have.

For your convenience we offer the options to apply by mail, through our website or fax. You may submit your completed application and supporting documentation to the addresses or fax number below.

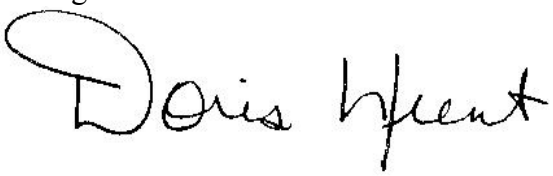
JPS Eligibility Center
1325 South Main Street
Fort Worth, TX 76104

Email: Enroll@jpshealth.org

Fax (817) 927-3834

Processing time may vary according to the number of applications received. We will contact you once an eligibility determination is made or if additional information is required. You may contact us at the above mentioned numbers or email to check the status of your financial screening. Thank you for choosing JPS and we look forward to providing quality healthcare to you and your family.

Regards-



Doris Hunt
Vice President of Finance

JPS Health Network

Application for JPS Connection Program

04/02/12

***Must provide two proofs of residence** (example - utility bill, lease agreement)

Name: _____ **Maiden Name**: _____
(Last) (First) (MI)

❑ Live w/ someone
❑ Rent ❑ **Home** #: _____
❑ Own ❑ **Cell**#: _____
Please check primary contact phone number

Address: _____
(Street) (Apt. #) (City) (State) (Zip) (County)

Are you a Tarrant County Resident? ❑ Yes ❑ No **Email Address**: _____

Primary Language: ❑English ❑Spanish ❑Vietnamese ❑Other _____

Marital Status: ❑ Single ❑ Separated ❑ Divorced ❑ Widowed ❑ Married** (If married, **spouse's signature is required**)

Ethnicity: ❑Caucasian ❑African-American ❑Hispanic ❑ Asian ❑ Native American ❑ Other _____

List the names of each person living in household (attach additional sheets as necessary)

***Must provide copies of identification documents** such as a driver's license or birth certificate, Immigration cards and Social Security cards

Full Name of Household Members:					
Relationship to applicant:	**Self**	**Spouse**	**Child**	**Child**	**Child**
Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of Birth					
Place of Birth					
Check one if applicable:	❑ US Citizen ❑ Perm. Resident	❑ US Citizen ❑ Perm. Resident	❑ US Citizen ❑ Perm. Resident	❑ US Citizen ❑ Perm. Resident	❑ US Citizen ❑ Perm. Resident
Social Security #					
Employed?	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Is pregnant?	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Insurance, Medicaid, Medicare?	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Is a Veteran?	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Indicate persons applying	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**

Monthly Income & Asset Information – Required for each member of household that receives income

***Must provide proof of income and assets** (example – 4 current check stubs, and bank statements, most recent tax returns, award letters)

Each box below must be addressed. Place a -0- or N/A in box if not applicable. Incomplete applications will be returned.

List household members names	**1)**	**2)**	**3)**	**4)**
Employer Name				
Employer Street Address				
Employer City/State/Zip				
Employer Phone #				
Employment Income - monthly	**$**	**$**	**$**	**$**
Self-employed income	**$**	**$**	**$**	**$**
Unemployment / Worker's Compensation	**$**	**$**	**$**	**$**
Child Support / Alimony	**$**	**$**	**$**	**$**
Pensions / Retirement	**$**	**$**	**$**	**$**
Social Security (SSI) (Disability)	**$**	**$**	**$**	**$**
VA Benefits	**$**	**$**	**$**	**$**
Year of last income tax return filed				
Gross taxable wages on tax return	**$**	**$**	**$**	**$**
Value of Assets				
Property – value of home, land, buildings	**$**	**$**	**$**	**$**
Bank Name(s)				
Bank Account Balances	**$**	**$**	**$**	**$**
IRA/CD/401k/403b & Other Investments	**$**	**$**	**$**	**$**
Major Expenses - Monthly				
Mortgage Payments/Rent	**$**	**$**	**$**	**$**
Child Support/Alimony	**$**	**$**	**$**	**$**
Automobile payment (if applicable)	**$**	**$**	**$**	**$**
Other Loan Payments	**$**	**$**	**$**	**$**

"I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under federal law and/or state law. Everything on this application is the truth as best I know it." If at any time false information is discovered, penalties will include, but are not limited to, loss of my benefits and the inability to reapply for the JPS Connection Program for no less than a period of ninety (90) days. **"I understand I am responsible for reporting any change in residence, household income, employment, family size or insurance coverage. I understand my membership will be put on hold if a change is not reported."** I authorize JPS Health Network to run a credit bureau report for the purpose of making a preliminary determination of whether I meet the eligibility requirements for the JPS Connection Program. I also understand that any approval will be conditional based on the information reviewed in my credit report.

Signature of Applicant: _____ Date: _____

**Signature of Co-Applicant/Spouse: _____ Date: _____

S**pouse's signature is required** to complete screening even if spouse is not requesting assistance at this time.

JPS Health Network

Documentation Requirements for
JPS Connection Indigent Healthcare Program

** Please provide all applicable items from following categories **

Please note that upon receipt of documentation <u>additional information</u> may be requested.

<u>Proof of Patient Identification</u> - Must provide one of the following:

- ❑ Driver's license or DPS ID card
- ❑ Birth Certificate (children under 18)
- ❑ Employee Identification card (with picture)
- ❑ School Identification card (with picture)

<u>Immigration documentation</u> - for all applicable household members:

- ❑ Resident alien cards (front and back), Visas and or Passports

<u>Bank Statements & Tax Returns</u> – Must be provided

- ❑ Most recent checking and savings account statements
- ❑ Entire 1040 Tax Return Form with: Schedule C, Partnership tax form 1065, Schedule K-1, Schedule F**,** W2 etc.
- ❑ Most recent statement of CD's, IRA's and other investments

<u>Proof of Employment and Income</u> – Must provide applicable sources of income

- ❑ Four most recent payroll check stubs
- ❑ Employment Verification form
- ❑ Current award letter / copies of checks: SSI, RSDI, VA, Soc. Sec., TANF
- ❑ Workman's Compensation
- ❑ Employer statement of earnings on letter head
- ❑ Court orders/check or debit card statement for Child Support /Alimony
- ❑ Unemployment Award letter, check stubs or Chase debit card statement
- ❑ Debit/Payroll card statements (if applicable)

<u>Verification sources of assistance</u> – Provide all applicable

- ❑ Food Stamp/TANF and Housing Assistance award letters
- ❑ Statement from Homeless Shelter where patient resides and verifying unemployment.
- ❑ **Verification of Assistance form with notary seal and <u>all</u> of the following proofs <u>from the person providing assistance</u>:**
  - ❑ Utility bill
  - ❑ Proof of income (upon request)
- ❑ **<u>Social Security Number</u>** – Provide for all applicable household members.

<u>Proof of Patient Residency</u> – Must provide a minimum of two

- ❑ Utility, telephone and cable bills
- ❑ Lease agreement, rent receipt, mortgage statement
- ❑ Auto, Life, Homeowners/Renter's Insurance Documents
- ❑ County, State/Federal agencies Correspondence
- ❑ Retirement Plan Documents, Attorney Correspondence
- ❑ Texas Department of Motor Vehicle Records
- ❑ Statement from Homeless Shelter

<u>Proof of Insurance</u> – Provide for all household members

- ❑ Front and back of Medical/Dental Insurance cards

<u>Proof of Self Employment</u> (No taxes withheld from income)

- ❑ Self Employment Form (1 form each month)
- ❑ Entire 1040 Tax Return Form with: Schedule C, 1099, Partnership Form 1065, Schedule K-1, Schedule F etc.
- ❑ Business ledgers/Accountant's statement listing income and expenses for the last 12 months
- ❑ 12 months of check stubs, receipts, or logs for income received: babysitting, contract/sub-contract work, landscaping, day labor work etc.

<u>Acceptable sources to verify deductions</u>

If desiring to claim deductions for child care, alimony or child support paid out:

- ❑ Statement listing last four payments to provider
- ❑ Last four canceled checks
- ❑ Copy of divorce decree stating amount owed
- ❑ Statement from Attorney General's office
- ❑ Statement from ex-spouse itemizing payments

<u>Assets, Debts & Liabilities</u> – Must provide if applicable

- ❑ Certificate or dividend statement
- ❑ Car title / make, model and value
- ❑ Individual Retirement Account
- ❑ Proof of insurance policies
- ❑ Property tax statement or deed/title
- ❑ Oil, gas, mineral rights (bring statement)
- ❑ Car loan agreement or statement
- ❑ Unpaid medical bills
- ❑ Lending institutions account #'s & available credit line

Please note **- Anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of the application process is committing a crime, which can be punished under Federal law, State law, or both.** If at any time false information is discovered penalties will include, but are not limited to, loss of my membership benefits and the inability to reapply for the JPS Connection Indigent Healthcare Program for no less than a period of ninety (90) days.

JPS Health Network
Membership Responsibilities for
JPS Connection Indigent Healthcare Program

_____ I understand that the JPS Connection does not cover all of the services provided at JPS Health Network including, but not limited to, dental, podiatry, cosmetic procedures, assisted reproductive technology and transplants.

_____ JPS Connection is a tax-supported medical program offered to eligible Tarrant County residents. JPS Connection offers low cost medical care available only through JPS Health Network facilities. I understand that JPS Connection is not an insurance company or an insurance plan.

_____ At this time, I am not covered under any third party commercial insurance, Medicaid and/or parts A&B of Medicare. I understand that if I am deemed eligible for state, federal or pharmaceutical assistance programs, I must comply with seeking that assistance. Failure to do so will make me ineligible for JPS Connection. Documentation provided to JPS Health Network will be used to apply for any coverage for which I may be potentially eligible.

_____ I am aware that when JPS Connection is used secondary to another payor, I am responsible for all physician/professional fees, co-payments and any deductibles related to professional services rendered. This includes, but not limited to, JPSPG, UNT, Sheridan, RadCare, EmCare or any other professional group you may receive bills from.

_____ As a JPS Connection member, I understand that I have an obligation to notify the Financial Screening department of JPS Health Network of any changes. I agree to inform the Financial Screening department of the JPS Health Network immediately of any changes in my Tarrant County residence, household income, family size and insurance coverage.

_____ I understand that the JPS Connection membership privileges are on a limited time basis. In order to continue receiving a discount on medical services, through the JPS Connection program, it will be necessary to complete another financial screening at the end of my enrollment period. You will be expected to pay all charges incurred after eligibility has expired.

_____ I acknowledge that should the JPS Health Network receive returned mail, from the mailing address I provided, that my JPS Connection membership privileges will be suspended pending further review.

_____ I understand that I am responsible for providing true and accurate documentation. If at any time false information is discovered penalties will include, but not limited to, loss of my membership benefits and the inability to reapply for the JPS Connection Indigent Healthcare Program for no less than a period of ninety (90) days.

"I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I know it."

Signature of Applicant: _____ Date: _____

Signature of Co-Applicant: _____ Date: _____

JPS Health Network

Verification of Assistance and Residency for JPS Connection Program

This form only needs to be completed if the applicant is being assisted by another individual.

I, _____ verify that _____
Name of person providing assistance — Applicant(s) full name

Patient's MR# _____ and/or Social Security # _____

lives at _____
Applicant(s) Address — City/Zip Code

Financial Assistance: I provide financial assistance to the applicant. Yes No

This individual is claimed as a dependent on my more recent filed income tax return. Yes No

Does the applicant have a job? _____ If yes, provide employer name_____

Does the applicant have another income source? _____ If yes, how much _____

I provide applicant with the following: ❑ Food ❑ Personal items ❑ Transportation

❑ Cash/Check $ _____ per Week or Month ❑ Other _____

Do you pay rent or other bills for this applicant? _____ If yes, how much and how often? _____

Residency Assistance:

- ❑ The applicant(s) resides at my Tarrant County residence.
- ❑ The applicant(s) does not pay rent to me.
- ❑ The applicant(s) pays _____ to help toward the rent and utilities.

How long has the applicant(s) resided at your address? _____

Does the applicant(s) have another residence? _____ If yes, where _____

Documentation Attached for Person Providing the Assistance:

- ❑ Provide proof of residence (if applicant lives with the person providing the assistance) refer to proof list
- ❑ Provide proof of income (only upon request)

Relationship of Person Providing the Assistance to the Applicant(s): _____

I certify that the above information is true and correct. "I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under federal law and/or state law. Everything on this application is the truth as best I know it."

Signature of the Person Providing the Assistance: _____

Address, City, State, Zip: _____

Phone Number: _____

Date signed: _____