WELCOME TO BULLDOG HEALTH CENTER

Dear Student/Staff/Parent or Guardian:

Bulldog Health Center and HealthReach Community Health Centers welcome you!

Healthcare services are offered to students in grades 9-12 and district staff throughout the school year.

What is the Bulldog Health Center?

- Bulldog Health Center is a nonprofit healthcare provider located in the school that is staffed with a Nurse Practitioner and Medical Assistant who are available for all students and staff.
- The purpose of the Bulldog Health Center is to provide affordable, high-quality healthcare in a friendly, confidential setting, at a time that is convenient to students, parents, and staff.
- By opting into these services and signing the attached paperwork, we can offer your child all the same healthcare needs that they would receive at their primary care office.
- The school nurse is still available, and we are on site Tuesday through Friday from 7:00am - 3:00pm to provide services that extend beyond the school nurse's scope of practice.

We offer a variety of different services:

- **Diagnosis and treatment of acute illnesses, such as strep throat**
- **Chronic condition management, such as asthma and diabetes**
- **Sports and yearly physicals**
- **Immunizations**
- **Prescription medications**
- **Reproductive healthcare and education**
- **Mental healthcare, such as anxiety & depression treatment**

- **APPOINTMENTS ARE AVAILABLE DURING SCHOOL HOURS, REDUCING DRIVING TIME FOR YOU AND KEEPING KIDS IN CLASS LONGER**
- **YOU CAN KEEP YOUR PRIMARY CARE PROVIDER AND UTILIZE TIGER HEALTH CENTER**
- **NO STUDENT IS DENIED SERVICES FOR INABILITY TO PAY**

To contact us, walk into Bulldog Health Center during open hours, call: (207) 861 - 9666,

or email: SBHCLawrence@HealthReach.org.

Welcome to Bulldog Health Center and HealthReach!

HEALTHREACH
SCHOOL-BASED HEALTH CENTERS

HealthReach Community Health Centers

PATIENT INFORMATION			
Last Name:	First:	MI:	Nickname:
Date of Birth: / /	Social Security #:	According to Insurance (Sex): ☐ M ☐ F	

Mailing Address:		Physical Address: ☐ Same as Mailing Address	
Street/PO Box:		Street:	
City:	State:	City:	State:
Zip Code +4:		Zip Code +4:	
Primary Phone: ☐ Cell ☐ Home ☐ Other		Secondary Phone: ☐ Cell ☐ Home ☐ Other	
Primary Care Clinician:		Dental Clinician:	
Email Address:			
You may opt out of receiving email communication from us at any time			

INSURANCE INFORMATION	
The receptionist will scan your insurance card(s). If your insurance card is not currently available, you risk getting billed.	
Primary Insurance Name:	Primary Insurance Policy #:
Name of Policy Holder (if different than patient):	
Secondary Insurance Name:	Secondary Insurance Policy #:
Name of Policy Holder (if different than patient):	

PAYMENT OF BENEFITS: I authorize my health insurance carrier(s) or other third-party payers responsible for payment for my health care, including Medicare, Maine Care and other governmental and commercial insurers, to pay the costs associated with health care services rendered to me by HealthReach Community Health Centers ("HRCHC"). I hereby assign to HRCHC any rights I might have to receive payment directly from such insurance carriers and third-party payers and authorize my insurance carriers and third-party payers to pay HRCHC directly for the health care services provided to me. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance (including copays, coinsurance, and deductibles) on my account for any health care services rendered by HRCHC. I understand that health information about me may be shared with my health insurance carrier(s) or other third-party payers responsible for paying for my health care.

GUARANTOR INFORMATION-Person Responsible for Payment of Services ☐ If Self, Check Here – If not Self, Fill in all information below			
Last Name:	First:	MI:	
Date of Birth: / /	Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other		
Mailing Address: (if different than patient)	City:	State:	Zip:
Primary Phone #1:	Secondary Phone #2:		

EMERGENCY CONTACT INFORMATION ☐ None ☐ Guarantor If Other, provide the requested information below	
Name:	Relationship:
Primary Phone #1:	Secondary Phone #2:

Name of Patient:	Date of Birth: / /

RACE (Check all that apply)				ETHNICITY (Choose one)	
	American Indian, or Alaska Native		More than one race		Chicano
	Asian		Native Hawaiian		Cuban
	Asian Indian		Other		Declined to Specify
	Black or African American		Other Pacific Islander		Hispanic or Latino
	Chinese		Other Pacific Islander (Not Hawaiian		Mexican
	Filipino		Samoan		Mexican American
	Guamanian or Chamorro		Vietnamese		Not Hispanic or Latino
	Hawaiian		White		Puerto Rican
	Japanese		Declined to Specify	CURRENTLY IN THE MILITARY OR A VETERAN?	
	Korean				Yes / No

PREFERRED LANGUAGE				ARE YOU IN NEED OF? (IF APPLICABLE)	
	English		Spanish		An Interpreter
	French		Other:		Sign Language

ARE YOU CURRENTLY WITHOUT HOUSING?				AGRICULTURAL WORKER (IF APPLICALBE)	
	Yes		No		Migrant Agricultural Worker (moves from place to place)
	Unknown/Unreported				Seasonal Agricultural Worker (does not move for work)

SEXUAL ORIENTATION				GENDER IDENTITY			
	Lesbian, Gay, Homosexual		Straight, Heterosexual		Female		Other:
	Bisexual		Something Else		Male		Declined to Answer
	Don't Know		Declined to Answer		Female-to-Male/Transgender Male/Trans Man		Male-to-Female/Transgender Female/Trans Woman

PREFERRED PRONOUNS		SEX ASSIGNED AT BIRTH	
	He/Him/His		Male
	She/Her/Hers		Female
	They/Them/Theirs		Declined to Answer

ANNUAL INCOME	
Family Size:	Annual Household Income:
Head of Household:	

What is a household?

Households refer to all people related by birth, marriage, or adoption who reside together, dependents, and others in the same tax household. Individuals who are 19 or older and not dependents living at the same address is considered separate households. The following comprises the household:

- The applicant
- Spouse
- Domestic Partner when the applicant provides greater than 50% of the financial support (necessary living expenses) of the domestic partner.

Domestic Partnerships are defined as two individuals who are unmarried, 19 years or older, and who reside together.

- Anyone under 19 years of age who lives with and is supported by the applicant.
- Anyone claimed as a dependent on the applicant's federal tax return.
- Anyone who claims the applicant on a federal tax return or is their tax dependent. If applicant is claimed as a dependent on a federal tax return, then the person(s) who claimed the applicant is considered part of the household and income verification is required.

Name of Patient:	Date of Birth: / /

CONSENT FOR TREATMENT IN OFFICE AND TELEHEALTH

1. I consent for HRCHC, and its providers and other staff, to provide telehealth services to me. Use of telehealth services is voluntary. Refusing telehealth services will not affect my right to future care and treatment. Telehealth services involve medical evaluation, diagnosis, and treatment using interactive audio, video, and data communication with my provider, who is at a different location than me. Telehealth appointments will not be audio or videotaped without my consent. I understand that the alternative to a telehealth visit is an in-person visit with a provider.
2. If I am a Maine Care member: (1) refusing telehealth services will not risk loss or withdrawal of my Maine Care benefits; and (2) Maine Care will pay for my transportation to receive Maine Care covered services as allowed under Maine Care rules.
3. Some services are not available through telehealth, such as services that require an in-person physical exam. Telehealth may not be appropriate for every medical condition. I may need to follow up with a health care provider in-person or receive diagnostic tests. My provider will tell me if further evaluation is needed. Certain medicines may not be prescribed for a telehealth visit. If I am experiencing a medical emergency, I will not try to contact my provider by telehealth. I understand that I should go to the nearest emergency room or dial 9-1-1 or another local emergency number.
4. I have the right to be informed of who will be present with my provider rendering telehealth services to me and at the site where I am receiving services. I have the right to exclude anyone from either site. I will be provided with contact information for the provider(s) and staff who will see me on each telehealth visit.
5. I will physically be in the State of Maine for each telehealth visit. HRCHC providers are licensed in Maine and there are restrictions on providing telehealth services to patients outside of Maine. If I am not in Maine, my provider may not legally be able to provide services to me. I will be asked to confirm my identity and location for each telehealth visit.
6. There are inherent risks in the use of telehealth. It is possible that transmission of data and equipment may fail or be disrupted or distorted. HRCHC takes reasonable steps to ensure its telehealth service is secure and complies with applicable privacy and security laws. However, it is impossible to fully guarantee against security or privacy risks. In addition, telehealth may not be as effective or complete as an in-person visit.
7. I will have access to all information resulting from telehealth services as provided by law. HRCHC may use and disclose this information as allowed by law. As part of the technologies used in providing telehealth services, information may be collected and passive tracking mechanisms may be used by these technologies. This information may include, without limitation, performance data and information related to my connection used in the visit, such as my name, IP address, location, and other details about the visit.
8. If I have a complaint about HRCHC's telehealth services, I may ask HRCHC how to make a complaint.
9. I am aware that the practice of medicine is not exactly scientific and that HRCHC offers no guarantees concerning any treatments or examinations I may have here.
10. I understand that HRCHC and its employees may use the information contained in my record for proper medical purposes, and for clinical improvement audits.
11. I authorize the medical staff of HRCHC to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess, diagnose, and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
12. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

NOTICE OF PRIVACY PRACTICES: By initialing it here, I acknowledge that I have received a copy of HealthReach Community Health Centers' Notice of Privacy Practices.
Patient/Authorized Representative* Initials in box (right): ☐

[Staff: If initials are not provided, document reason.]

SIGNATURE: By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

_____ ____/____/_____

Signature of Patient or Authorized Representative* Date

**If signed by an Authorized Representative:*

_____ _____

Printed Name of Authorized Representative Source of Authority (e.g., guardian, power of attorney)

HEALTHREACH
COMMUNITY HEALTH CENTERS

HealthReach Community Health Centers New Patient History Form - Pediatric

Patient Information:

- **Full Name:** _____ **Preferred Name**: _____
- **Date of Birth:** _____
- **Sex assigned at birth:** ☐ female ☐ male ☐ intersex ☐ Prefer not to say/other
- **Your child's gender:** ☐ girl ☐ boy ☐ nonbinary ☐ Prefer not to say/other

Birth History:

- Birth weight: _____ lb. ____oz
- Was the baby born at term? ☐ Yes ☐ No, baby was born at _____ weeks
- Were there any complications before birth or after birth? ☐ No ☐ Yes
  _____
- During pregnancy, did the mother use: ☐ tobacco ☐ alcohol ☐ other substances_____
- Normal newborn screen at birth? ☐ Yes ☐ No _____
- Normal hearing screen at birth? ☐ Yes ☐ No _____

Medical History:

1. **Allergies** (Medications, Food, Environmental):
   ☐ **None**

My child has an allergy to...	Their reaction

2. **Current Medications** (Include over the counter, vitamins, supplements):
   ☐ **None**

Drug Name	Dose	How taken?	Who Prescribes?

HEALTHREACH
COMMUNITY HEALTH CENTERS

3. **Current Medical or Mental Health Conditions** (e.g., asthma, migraines, ADHD):
   ☐ **None**

Condition	Does your child see a specialist for this?

4. **Past Surgeries or Health Issues**:
   ☐ **None**

Surgery/Health Issue	Date

5. **Immunization History**:
   My child is up to date for immunizations: ☐ **Yes** ☐ **No** (please provide a copy of your child's immunization records if you are transferring from another state)

6. **Family Medical History**:
   ☐ **Not sure**

Child's Family Member	Health Conditions

7. **School History:**
   ☐ **None**
   Name of school: _____ Current grade level: _____
   Does your child receive any services for learning difficulties? ☐ No ☐ Yes If so, what type of services: _____

8. **Is there anything else that you feel we should know about your child?**

_____

_____

_____

Parent or Guardian,

The following two Authorization to Disclose forms appear the same. BOTH forms should be filled out individually.

The first form should be filled with your child's current primary care provider's (PCP) contact information. This allows us to receive your child's medical history in order to provide the most appropriate care for your child's needs. If you would like us to become your child's exclusive PCP, please select "Transfer of Care" in the "Purpose for Release" section. If you would like their current provider to remain their PCP, and us to provide healthcare support services in addition to their primary care, please select "Other".

The second form should be filled with the school's contact information if you would like us to be able to work with the school nurse and counselor to provide the most appropriate care for your child's needs.

BULLDOG HEALTH CENTER
HEALTHREACH

HEALTHREACH
COMMUNITY HEALTH CENTERS

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Belgrade Regional Health
4 Clement Way
Belgrade, ME 04917-4370
Fax: 207-495-3353

Bethel Family Health Center
32 Railroad St | PO Box 1367
Bethel, ME 04217-1367
Fax: 207-824-0012

Bingham Area Health & Dental Center
237 Main St | PO Box 746
Bingham, ME 04920-0746
Health Fax: 207-672-3641
Dental Fax: 207-672-4829

Bulldog Health Center
Lawrence High School
9 School St
Fairfield, ME 04920-0746
Fax: 207-861-9625

Lovejoy Health Center
7 School St, Suite 1
Albion, ME 04910-6501
Fax: 207-861-9624

Madison Area Health Center
8 South Main St
Madison, ME 04950-4501
Fax: 207-696-3974

Mt. Abram Regional Health Center
25 Depot St
Kingfield, ME 04947-4208
Fax: 207-265-5004

Rangeley Family Medicine
42 Dallas Hill Rd | PO Box 569
Rangeley, ME 04970-0569
Fax: 207-864-2969

Richmond Area Health
24 Gardiner St
Richmond, ME 04357-1336
Fax: 207-737-4412

Sheepscot Valley Health Center
47 Main St | PO Box 207
Coopers Mills, ME 04341
Fax: 207-549-3439

Strong Area Health & Dental Center
177 North Main St
Strong, ME 04983-3005
Health Fax: 207-684-3368
Dental Fax: 207-684-3049

Tiger Health Center
Gardiner Area High School
40 W Hill Rd
Gardiner, ME 04345
Fax: 207-861-9630

Western Maine Family Health Center
16 Depot St, Suite 300
Livermore Falls, ME 04254-1311
Fax: 207-897-2321

Name:_____ **DOB:** _____

Name used when treatment occurred (if different from above): _____

Use this form to give permission to HRCHC to share or receive your medical records and information containing protected health information with or from the entity or person listed below.

I give permission to HRCHC:

☐ To **GIVE** my healthcare information to: ☐ To **GET** my healthcare information from:

Person's Name or Entity: _____

Street Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Purpose of Release (check all that apply):

☐ Personal Use ☐ Legal Purposes ☐ Transfer of Care ☐ Other: _____

Identify what medical records and information should be included in the protected health information:

☐ Office visit notes ☐ Laboratory/Pathology Results ☐ Imaging Results ☐ Hospital Documents
☐ Consultant reports ☐ HRCHC Behavioral Health Records ☐ Immunizations ☐ Diagnostic
☐ Entire Medical Record ☐ Dental Records: Notes and Imaging ☐ Other:_____

Records for these dates: From: _____ To: _____

***HRCHC will release physical or digital medical records for the last 3 years unless other dates are specified above.**

☐ **If HRCHC is disclosing your records: Check Here if you want to review the records before they are released. Please make an appointment to view the records in our Office before the records are released.**

HEALTHREACH
COMMUNITY HEALTH CENTERS

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name:_____ **DOB:** _____

If I have been diagnosed or treated for any of the following, I understand that the disclosing entity needs my specific consent. Indicate whether you DO or DO NOT authorize the release of protected health information for each of the following by initialing the appropriate box.

I DO	**I DO NOT**	Authorize the release of PHI regarding treatment for **SUBSTANCE USE DISORDER PROGRAM RECORDS AND INFORMATION PROTECTED BY 42 C.F.R PART 2.**
initials	**initials**	
I DO	**I DO NOT**	Authorize the release of PHI regarding treatment **outside** of HRCHC for **MENTAL HEALTH AND BEHAVIORAL HEALTH**. I understand that I have the right to review any medical records containing PHI related to my mental and behavioral health that is maintained by licensed mental health facilities or agencies at any reasonable time before deciding to authorize the disclosure on this form.
initials	**initials**	
I DO	**I DO NOT**	Authorize the disclosure of **HIV/AIDS INFORMATION, INCLUDING** test results. I understand that there are potential risks associated with the disclosure of HIV/AIDS information including but not limited to discrimination and changes in family and social relationships.
initials	**initials**	

I understand that:

- I can withdraw my consent at any time by completing a revocation form available at one of our health centers, subject to the right of any person who acted in reliance of this authorization before receiving notice that it was revoked.
- I can refuse to disclose some or all my records. But if I do so, it could result in an improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences. Partial or incomplete records will be labeled as such to inform the provider receiving them of their status. The health center will not withhold treatment whether I provide this permission form or withdraw my consent to disclose Protected Health Information except as authorized by law.
- I am entitled to a copy of this authorization form.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I permit HRCHC to use this form to make additional disclosures of information permitted by this form.

This form will **expire one year** from the date signed unless I revoke my permission sooner or provide an earlier expiration date. If you would like to provide an expiration date, please inform your health center.

I, the undersigned, hereby authorize the disclosing entity and its designated employees or agents to release/obtain/discuss medical information from my health record.

_____ _____

Signature of Patient/Authorized Representative | Date | Legal Authority

Describe your legal authority to act on behalf of the patient (e.g., Guardian, Power of Attorney agent). We may require documentation of your authority.

Please Print Name:_____ Phone #: _____

*** Signature by an authorized representative certifies to the disclosing entity that such person has the legal authority indicated to authorize disclosure of the patient's information and records on behalf of the patient.

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2; (ii) you are a covered entity or business associate and have received the record for treatment, payment, or health care operations; or (iii) you have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

HEALTHREACH
COMMUNITY HEALTH CENTERS

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Belgrade Regional Health
4 Clement Way
Belgrade, ME 04917-4370
Fax: 207-495-3353

Bethel Family Health Center
32 Railroad St | PO Box 1367
Bethel, ME 04217-1367
Fax: 207-824-0012

Bingham Area Health & Dental Center
237 Main St | PO Box 746
Bingham, ME 04920-0746
Health Fax: 207-672-3641
Dental Fax: 207-672-4829

Bulldog Health Center
Lawrence High School
9 School St
Fairfield, ME 04920-0746
Fax: 207-861-9625

Lovejoy Health Center
7 School St, Suite 1
Albion, ME 04910-6501
Fax: 207-861-9624

Madison Area Health Center
8 South Main St
Madison, ME 04950-4501
Fax: 207-696-3974

Mt. Abram Regional Health Center
25 Depot St
Kingfield, ME 04947-4208
Fax: 207-265-5004

Rangeley Family Medicine
42 Dallas Hill Rd | PO Box 569
Rangeley, ME 04970-0569
Fax: 207-864-2969

Richmond Area Health
24 Gardiner St
Richmond, ME 04357-1336
Fax: 207-737-4412

Sheepscot Valley Health Center
47 Main St | PO Box 207
Coopers Mills, ME 04341
Fax: 207-549-3439

Strong Area Health & Dental Center
177 North Main St
Strong, ME 04983-3005
Health Fax: 207-684-3368
Dental Fax: 207-684-3049

Tiger Health Center
Gardiner Area High School
40 W Hill Rd
Gardiner, ME 04345
Fax: 207-861-9630

Western Maine Family Health Center
16 Depot St, Suite 300
Livermore Falls, ME 04254-1311
Fax: 207-897-2321

Name:_____ **DOB:** _____

Name used when treatment occurred (if different from above): _____

Use this form to give permission to HRCHC to share or receive your medical records and information containing protected health information with or from the entity or person listed below.

I give permission to HRCHC:

☐ To **GIVE** my healthcare information to: ☐ To **GET** my healthcare information from:

Person's Name or Entity: _____

Street Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Purpose of Release (check all that apply):

☐ Personal Use ☐ Legal Purposes ☐ Transfer of Care ☐ Other: _____

Identify what medical records and information should be included in the protected health information:

☐ Office visit notes ☐ Laboratory/Pathology Results ☐ Imaging Results ☐ Hospital Documents
☐ Consultant reports ☐ HRCHC Behavioral Health Records ☐ Immunizations ☐ Diagnostic
☐ Entire Medical Record ☐ Dental Records: Notes and Imaging ☐ Other:_____

Records for these dates: From: _____ To: _____

***HRCHC will release physical or digital medical records for the last 3 years unless other dates are specified above.**

☐ **If HRCHC is disclosing your records: Check Here if you want to review the records before they are released. Please make an appointment to view the records in our Office before the records are released.**

HEALTHREACH
COMMUNITY HEALTH CENTERS

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name:_____ **DOB:** _____

If I have been diagnosed or treated for any of the following, I understand that the disclosing entity needs my specific consent. Indicate whether you DO or DO NOT authorize the release of protected health information for each of the following by initialing the appropriate box.

I DO	**I DO NOT**	Authorize the release of PHI regarding treatment for **SUBSTANCE USE DISORDER PROGRAM RECORDS AND INFORMATION PROTECTED BY 42 C.F.R PART 2.**
initials	**initials**	
I DO	**I DO NOT**	Authorize the release of PHI regarding treatment **outside** of HRCHC for **MENTAL HEALTH AND BEHAVIORAL HEALTH**. I understand that I have the right to review any medical records containing PHI related to my mental and behavioral health that is maintained by licensed mental health facilities or agencies at any reasonable time before deciding to authorize the disclosure on this form.
initials	**initials**	
I DO	**I DO NOT**	Authorize the disclosure of **HIV/AIDS INFORMATION, INCLUDING** test results. I understand that there are potential risks associated with the disclosure of HIV/AIDS information including but not limited to discrimination and changes in family and social relationships.
initials	**initials**	

I understand that:

- I can withdraw my consent at any time by completing a revocation form available at one of our health centers, subject to the right of any person who acted in reliance of this authorization before receiving notice that it was revoked.
- I can refuse to disclose some or all my records. But if I do so, it could result in an improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences. Partial or incomplete records will be labeled as such to inform the provider receiving them of their status. The health center will not withhold treatment whether I provide this permission form or withdraw my consent to disclose Protected Health Information except as authorized by law.
- I am entitled to a copy of this authorization form.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I permit HRCHC to use this form to make additional disclosures of information permitted by this form.

This form will **expire one year** from the date signed unless I revoke my permission sooner or provide an earlier expiration date. If you would like to provide an expiration date, please inform your health center.

I, the undersigned, hereby authorize the disclosing entity and its designated employees or agents to release/obtain/discuss medical information from my health record.

_____ _____

Signature of Patient/Authorized Representative | Date | Legal Authority

Describe your legal authority to act on behalf of the patient (e.g., Guardian, Power of Attorney agent). We may require documentation of your authority.

Please Print Name:_____ Phone #: _____

*** Signature by an authorized representative certifies to the disclosing entity that such person has the legal authority indicated to authorize disclosure of the patient's information and records on behalf of the patient.

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2; (ii) you are a covered entity or business associate and have received the record for treatment, payment, or health care operations; or (iii) you have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

*HRCHC Affordable Care Application 2026 Health/Dental Center Name:*_____

This is an application for the sliding fee program at HealthReach Community Health Centers. This program offers a discount on services provided at our health/dental centers. This is not an insurance program.

A) Your information: (Applicant)

Name: **Mailing Address:**

Phone:

B) List yourself and family/household members – **see FAQs for definition of household.**

Name	DOB	Relationship	Income	Applying for Program
1.			Y N	Y N
2.			Y N	Y N
3.			Y N	Y N
4.			Y N	Y N
5.			Y N	Y N
6.			Y N	Y N

Proof of Income

1) **Are you Employed?** **No** ____ **Yes** ____ (if yes send one of the below)
- The first 2 pages of your most recent Federal Income Tax return -Adjusted Gross Income
- W-2 form- Gross Income
- Recent 2 consecutive pay stubs *Indicate if paid weekly, bi- weekly, etc.– Gross Income

Important note: If you are a seasonal worker, please note average weeks worked.

2) **Are you Self Employed?** **No** ____ **Yes** ____ (if yes send one of the below)
- First 2 pages of 1040 of your most recent Federal Income Tax return
- Or last 3 months profit and loss statement. Call 660-9922 to request P&L sheet if need be.

3) **Are you receiving Unemployment Benefits?** **No** ____ **Yes** ____ (if yes send the below)
- Notice from Department of Labor showing maximum benefit amount, the first letter you received.

4) **Do you receive other Income?** **No** ____ **Yes** ____ (send all items listed below that apply)
- Social Security: Recent social security notice or copy of bank statement showing direct deposit.
- Pensions: Copy of recent checks
- Child Support/Alimony: Copy of legal document or recent check payable.
- Disability benefit notice
- Worker's compensation notice
- Widows benefit income notice
- Other income from miscellaneous sources (example: rental income, TANF, Interest, Dividends)

5) If you receive **NO** financial assistance and have **NO** income, please provide a signed letter from the family member or friend providing your support. If you have no one assisting you, please provide a written explanation of how your living exp enses are paid.

6) Any requests for exceptions to these guidelines must be made in writing and require approval by the Revenue Cycle Manager and/or Director of Finance

If you would like help applying for MaineCare, Breast and Cervical Health Program, Hospital free care or the Health Insurance Marketplace circle **YES**

PENALTIES FOR MISREPRESENTATION: I certify that all of the information is true and correct and that all income is reported. I understand that this information is being provided for the receipt of Federal funds; that institution officials may verify the information on the statement and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

X_____

Applicant's Signature (or advocate) Date

HealthReach Community Health Centers' Affordable Care Program FAQs

1. **How soon will a decision be made?**
   - The application will be processed within 5 business days.
   - The 1st day of the month the application is approved will be the effective date.
   - As long as there is no change in your income or family size, the level of discount is good for 12 months.
   - You will be notified by mail when it is time to renew your application.

2. **What is the applicants' responsibility?**
   - It is your responsibility to notify us immediately in writing if your income or family size changes.
   - It is your responsibility to notify us as soon as possible of any address changes.

3. **What does the HealthReach Affordable Care Program Cover?**
   - Visits to any HealthReach Health or Dental Center
   - Supplies used at Health Center visits
   - Lab tests performed and lab specimens collected at the Health Center - you will receive a separate bill for any lab tests sent out to be processed (NorDx Lab)

4. **What is a household?**
   Household refers to all persons related by birth, marriage, or adoption who reside together, dependents, and others in the same tax household. Individuals who are 19 or older and not dependents living at the same address are considered separate households. The following compose the household:

   - The applicant
   - Spouse
   - Domestic Partner when the applicant provides greater than 50% of the financial support (necessary living expenses) of the domestic partner.
     - Domestic Partnerships are defined as two individuals who are unmarried, 19 years or older, and who reside together.
   - Anyone under 19 years of age who lives with and is supported by the applicant.
   - Anyone claimed as a dependent on the applicant's federal tax return.
   - Anyone who claims the applicant on a federal tax return or is their tax dependent. If applicant is claimed as a dependent on a federal tax return, then the person(s) who claimed the applicant is considered part of the household and income verification is required.

Bring this form to your health or dental center signed and with proof of income.

Or Email it to: Patient.Accounts@Healthreach.org (note: this is an unsecure email account)

Or through the patient portal (secure) click on "I have a HealthReach billing question" and attach your documents and note sliding fee application in the subject line.

Or Mail it to:

HealthReach Community Health Centers
Attn: Patient Billing
PO Box 727
Waterville, ME 04903-0727

Telephone: (207) 660-9922 option 1
Toll Free: 1-800-299-2460

Your Fees Will Be Reduced if:	
Your family size is	and your family's income is less than:
1	$31,921
2	$43,281
3	$54,641
4	$66,001
5	$77,361
6	$88,721
7	$100,081
8	$111,441