



PATIENT VISIT FORM

Today's date (MM/DD/YYYY): / /

PARTICIPATION INFORMATION AND QUALIFICATION VERIFICATION

**TO BE COMPLETED BY THE TERMINATED PERSON
OR HIS OR HER SPOUSE/SAME SEX DOMESTIC PARTNER
ON BEHALF OF ALL FAMILY MEMBERS**

(Please Print)

Please check appropriate responses.

1. PLEASE IDENTIFY YOUR AGE:

ARE YOU 19 YEARS OF AGE OR OLDER?

YES If YES please proceed to next question.

NO If NO please **STOP**; you are not qualified to complete this Patient Visit Form.

2. PLEASE IDENTIFY WHO YOU ARE:

Terminated Person (Person whose employment terminated on or after March 31, 2009).

The Spouse/Same-Sex Domestic Partner of the Terminated Person.

TERMINATED PERSON:

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY): / /	Social Security# (XXX-XX-XXXX):
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Street Address:

City:	State:	ZIP Code:	Home Phone # (XXX-XXX-XXXX):	Cell Phone # (XXX-XXX-XXXX):
Prior Health Coverage Provider Name:	ID Number:	Group Number:		

SPOUSE/SAME-SEX DOMESTIC PARTNER:

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY): / /	Social Security# (XXX-XX-XXXX):
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Street Address (If Different):

City:	State:	ZIP Code:	Home Phone # (XXX-XXX-XXXX):	Cell Phone # (XXX-XXX-XXXX):
Prior Health Coverage Provider Name:	ID Number:	Group Number:		

3. PLEASE CONFIRM UNEMPLOYMENT BENEFIT STATUS

IS THE TERMINATED PERSON STILL ELIGIBLE FOR FEDERAL OR STATE UNEMPLOYMENT BENEFITS?

- YES If YES please proceed to next question.
- NO If NO please **STOP**; the Terminated Person and all related parties **DO NOT** qualify for TCRP.

IS THE TERMINATED PERSON CURRENTLY RECEIVING UNEMPLOYMENT BENEFITS?

- YES If YES please attach a copy of evidence that the Terminated Person has received a federal or state unemployment benefit payment (eg a copy of the unemployment benefit payment stub) within the last 30 days. If the Terminated Person does not currently have a copy of evidence that the Terminated Person has received a federal or state unemployment benefit payment within the last 30 days, the Terminated Person must submit such evidence to Take Care Health Systems within 21 days of submitting this Patient Visit Form. In the event the Terminated Person fails to submit the evidence within 21 days, then the Terminated Person and all related parties **DO NOT QUALIFY FOR TCRP AND MUST PAY FOR ALL SERVICES RECEIVED AT THE TAKE CARE CLINIC.**
- NO If NO please proceed to next question.

HAS THE TERMINATED PERSON APPLIED FOR UNEMPLOYMENT BENEFITS BUT IS STILL WAITING FOR A GOVERNMENT DETERMINATION THAT THE TERMINATED PERSON QUALIFIES FOR UNEMPLOYMENT BENEFITS?

- YES If YES please provide the date of application: _____. If the Terminated Person does not currently have a copy of a government issued determination letter stating that the Terminated Person qualifies for unemployment benefits, the Terminated Person must submit a copy of the determination letter to Take Care Health Systems within 21 days of submitting the original completed Initial Certification Form (First Visit). In the event the Terminated Person fails to submit the government issued determination letter within 21 days of submitting the original completed Initial Certification Form (First Visit) then the Terminated Person and all related parties **DO NOT QUALIFY FOR TCRP AND MUST PAY FOR ALL SERVICES RECEIVED AT THE TAKE CARE CLINIC.**
- NO If NO please proceed to next question. In the event that the Terminated Person does not apply for unemployment benefits and receive a government issued determination letter evidencing the Terminated Person's qualification for unemployment benefits and submit such determination letter to Take Care Health Systems within 21 days of submitting the original completed Initial Certification Form (First Visit) to Take Care Health Systems, the Terminated Person and all related parties **DO NOT QUALIFY FOR TCRP AND MUST PAY FOR ALL SERVICES RECEIVED AT THE TAKE CARE CLINIC.**

4. WHO IS THE PATIENT TODAY

- TERMINATED PERSON
- TERMINATED PERSON'S SPOUSE/SAME-SEX DOMESTIC PARTNER
- TERMINATED PERSON'S CHILD (18 months through 18 years of age)
- SPOUSE/SAME-SEX DOMESTIC PARTNER'S CHILD (18 months through 18 years of age)

Please fill out the following information for the patient:

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY): / /	Social Security# (XXX-XX-XXXX):
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5. PLEASE CONFIRM PATIENT'S UNINSURED STATUS

DOES PATIENT HAVE ANY TYPE OF HEALTH INSURANCE OR HEALTH COVERAGE?

- YES If YES please **STOP**: Patient **DOES NOT** qualify for TCRP offer.
- NO

ADDITIONAL INFORMATION

Take Care Clinic you are requesting to visit:

May we contact you in the future regarding news about Take Care Clinics? Yes No

Take Care Health Systems will send confirmation of qualification or disqualification for the TCRP offer for this patient visit to the email address listed below. If you do not have email, please provide alternative contact information. By providing your contact information below you authorize Take Care Health Systems to contact you to provide such notification of qualification or disqualification for TCRP offer for this patient. All Take Care Health Systems decisions about whether this patient qualifies for TCRP offer are final.

Your Email Address: _____

Your Mailing Address: _____

Your Phone Number: _____

I certify that all information provided in this Patient Visit Form is true, accurate and complete and understand that any false, fraudulent, fictitious or misleading information may result in disqualification from participating in the Take Care Recovery Plan offer.

I further certify that the Terminated Person identified in this Patient Visit Form is receiving, or is waiting for a determination from a government agency that s/he is eligible to receive, unemployment benefits as a result of a termination of employment occurring on or after March 31, 2009 and that, as a condition to participation in the Take Care Recovery Plan offer the Terminated Person must submit all supporting documentation, including verification of unemployment benefits, along with this Patient Visit Form or within twenty-one (21) days of submitting this Patient Visit Form to Take Care Health Systems. I understand that this Patient Visit Form is considered submitted to Take Care Health Systems on the date it is faxed or mailed to Take Care Health Systems or delivered to a Take Care Clinic. I understand that failure to provide all supporting documentation, including verification of unemployment benefits, will result in disqualification from participation in the Take Care Recovery Plan offer.

I further certify that all Family Members seeking free limited primary health care and diagnostic testing services pursuant to the Take Care Recovery Plan offer are not covered under any publicly funded or private health insurance plan or any other health coverage program, including COBRA coverage, Medicare and Medicaid. I further agree that if any Family Member does not qualify for the Take Care Recovery Plan offer at the time of the patient visit, he or she will be financially responsible for the cost of his/her visit and that Take Care Clinic shall bill the Family Member the Take Care Clinic regular charge for the health care and diagnostic testing services provided. I understand that if any Family Member receives services in a Take Care Clinic and is found to have health coverage or health insurance of any kind, Take Care Health Systems will submit a claim for reimbursement to the health coverage or health insurance provider for all services provided. I agree that such Family Member shall execute any and all required documents and take any actions necessary for Take Care Health Systems to receive reimbursement from the health coverage or health insurance provider.

I further certify that any same-sex domestic partner indicated above is in a domestic partnership with the Terminated Person which has been in existence for a period of at least six (6) months; that the Terminated Person and the same-sex domestic partner are not blood relatives and neither is legally married to any other individual.

I understand that the Take Care Recovery Plan offer is NOT insurance, NOT a medical discount plan and NOT a healthcare discount program and that the Take Care Recovery Plan offer has not been reviewed or endorsed by any regulatory authority.

Lastly, I certify that I have read, understand and agree to the TERMS AND CONDITIONS of the Take Care Recovery Plan offer.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

Please fax or mail this *Patient Visit Form* and all supporting documentation to:

**Take Care Health Systems
Attention: Take Care Recovery Plan
4165 30th Avenue South – Suite 101
Fargo, ND 58104-8419
FAX #: 1-866-656-8518**