



POLK HEALTHCARE PLAN

Member Contract for Care

The Polk HealthCare Plan (hereafter referred to as 'the Plan') is a managed health care program administered by Polk County Government in accordance with Florida Law (F.S. 212.055(7)) and Polk County Ordinance (03-89). The Plan is funded through a half-cent sales tax approved by Polk County voters in 2004. The Plan is not a licensed insurance company and is available only to eligible full-time, permanent, Polk County residents.

The Plan's goal is to provide quality, cost-effective and broad health care services to low-income Polk County residents who do not have and cannot get other health insurance.

I, _____ enter into this Agreement with the Polk HealthCare Plan to receive taxpayer-funded health services and furthermore

I certify:

1. I am an established, permanent, full-time Polk County resident with intent to remain.
2. I am not covered by, and cannot be covered by, any other health insurance.
3. My income is at or below 100% of Federal Poverty Level (FPL).
4. I meet the asset limits set by the Plan.
 - A. \$2,000 for household of one.
 - B. \$3,000 for household of two or more.
 - C. Excluded from assets:
 - 1) Homestead property
 - 2) One vehicle
5. I am an individual between 19-64 years old.
6. I am a United States citizen, or a lawfully admitted alien.
7. I have a Social Security card that is valid for employment and a valid photo ID.

I agree:

1. That I am receiving benefits paid for by Polk County taxpayers and I am responsible for following the Polk HealthCare Plan rules.
2. To recognize that the benefits made available to me are not governed by the same rules as commercial health insurance companies.
3. To report any increase of assets or income to the Plan within 15 days of changes.

Member Contract for Care-Continued

4. To report any changes in my name within 15 days of changes.
5. To report any changes in household size within 15 days of changes.
6. To report any changes of benefits received, such as Medicaid, Medicare, private insurance, Workers' Compensation, settlements, Victim of Crime Compensation, etc., within 15 days.
7. To report any change of address to the Plan within 15 days of changes.
8. To notify the Plan if I relocate to another county, state or country within 15 days of moving.
9. To apply for other benefits I may be eligible for.
10. To obtain transportation for my appointments and/or provide notice to the Plan's transportation service three days prior to appointment.
11. To attend my scheduled appointments and to notify my provider ahead of time to cancel if I am unable to keep my appointment with the understanding that I may lose my right to coverage under the Plan if I miss three scheduled appointments in a one year period without notifying my provider of cancellation.
12. To allow the exchange of Personal Health Information (PHI) as it relates to coordination of medical care and benefits. (For example, doctors, nurses, Plan staff, etc.)
13. To follow doctors' care plans including, but not limited to, medications, testing, appointments, patient education classes, following physician's advice, etc.
14. To advise my physicians of all treatment provided and medications prescribed by any other practitioner who may be caring for me.

I acknowledge that by signing my name or placing my mark on this form, I am verifying that I understand my rights and responsibilities and have read, received, and/or have had explained to me the following forms, declarations and releases as an enrollee in the Plan:

- HIPAA and Privacy Act Statement
- Polk HealthCare Benefit Handbook
- Specific Drug Formulary List
- Social Security Administration Consent for Release of Information
- Authorization for Release of Information
- Reimbursement Form

I understand that the Plan may end my coverage for these reasons:

1. Repeated noncompliance or misconduct:
 - A. Changing Plan enrollment card
 - B. Allowing someone else to use your enrollment card

Member Contract for Care-Continued

- C. Acts or threats of violence to Plan staff or providers
 - D. Changing written prescriptions
 - E. Prescription abuse or illegal drug use
 - F. Forgery of a prescription
 - G .Disruptive or verbal abuse of staff or providers
 - H. Inappropriate use of Emergency Room
 - I. Three different Plan providers dismiss you from their patient panel
2. Abuse or mistreatment of Plan
 3. Providing false eligibility information either by providing incorrect information, or forgetting to provide information
 4. Failure to report other payor sources, such as Workers' Compensation, Medicaid, Medicare, private insurance, settlements, Victims of Crime Compensation, etc
 5. Incarceration
 6. Failure to be employed during 12 consecutive months, if appropriate, without a doctor's statement or job search record

I acknowledge that I, and/or any family member in my household who may have been determined eligible for the Plan, was enrolled based on the information I provided at my interview.

I certify that the information I presented is true and correct to the best of my knowledge.

I understand that if I willfully withheld and/or gave wrong information on purpose for my gain, I may be required to pay in full, for any medical services I/we received while under the Plan.

I agree to conform with and abide by the policies for the Plan set forth in this contract on this _____ day of _____, 20 ____, at _____, Polk County, Florida.

Member Signature

Member Signature

Member Services Representative Signature

ORIGINAL ON FILE WITH THE POLK HEALTHCARE PLAN