



Information and Application

The goal of the Toledo/Lucas County CareNet Pilot Program is to coordinate low cost primary and hospital healthcare services for low-income residents of Lucas County who do not have health insurance and do not qualify for governmental health care programs. (Not all healthcare services are part of the program.)

Benefits of Becoming a Member

- Doctor visits including illness care are provided at a low cost based on your household income.
- Pregnancy-based care (members may be rescreened for eligibility in other assistance programs).
- Hospital-based services (members may be rescreened for eligibility in other assistance programs).
- Additional services available depending on primary care site.
- Free TARTA Bus transportation to doctor appointments (up to 8 roundtrips each year).

You can become a member if you meet all of the following:

- You cooperate with the CareNet application process.
- You have been a resident of Lucas County for at least 6 months.
- You are not eligible for any government healthcare programs.
- You are not eligible for or do not have any other form of health insurance coverage.
- Your household size and annual income is in the following ranges:
 - Household of 1 up to \$21,660
 - Household of 2 up to \$29,140
 - Household of 3 up to \$36,620
 - Household of 4 up to \$44,100
 - Household of 5 up to \$51,580
 - Household of 6 up to \$59,060
 - Household of 7 up to \$66,540
 - Household of 8 up to \$74,020

To Apply

Fill out as much of the attached Healthcare Financial Assistance Application as you can and provide a copy of your pay stubs or proof of other income for the last year.

1. Choose your healthcare provider from the list on the next page.
2. Contact the enrollment site for the healthcare provider you select and make an appointment or stop in during available hours to meet with an enrollment staff member to determine your eligibility to become a CareNet member.
3. As soon as you are considered eligible, you will be enrolled.

Bring the following items with you to enroll:

- Completed application.
- Income verification: including – tax returns, pay stubs, W-2's, self-employment records, award letter, bank statements or other documents containing income information.
- Proof of residency: such as a driver's license.

Toledo/Lucas County CareNet Primary Care Healthcare Providers, Services, Hours, Enrollment Information

HEALTHCARE PROVIDERS	SERVICES	DAY OF WEEK/HOURS	ENROLLMENT SITE
Cordelia Martin Community Health Center 430 Nebraska Avenue (behind Samuel M. Jones at Gunckel Park Middle School) Toledo, OH 43604 (419) 255-7883	Adult Primary Care Obstetrics Dental, ext. 169 Appt, ext. 100 WIC, ext. 108 Pharmacy, ext. 171 Social Serv, ext 111or 112	8:30 am - 4:30 pm Mon - Fri and 1st & 3rd Saturdays...by Appointments <u>only</u>	Cordelia Martin Health Center 430 Nebraska Avenue (behind Samuel M. Jones at Gunckel Park Middle School) <u>Correspondence mailed to :</u> Cordelia Martin 313 Jefferson Ave. Toledo, OH 43604 ATTN: _____ <u>Dental Information:</u> *you do NOT have to be an NHA patient to make an appointment* - Pediatric Clinic -1st Satur. Of the Month, 10 am – 1:30 pm, Minimum \$17.00 419-255-7883, ext. 169 - Adult Clinic – Mon,Tue & Thur. 8:30am – 4pm 419-255-7883, ext. 169
Rivereast Community Health Center 117 Main Street Toledo, OH 43605 (419) 691-1322	Adult Primary Care Obstetrics Appt., ext. 300 WIC, ext. 317 Social Service, ext. 314	8:30 am - 5:00 pm Mon - Fri	
Southside Community Health Center 732 South Avenue Toledo, OH 43609 (419) 241-6106	Adult Primary Care Appt., ext. 200 Infor., ext. 200 Social Service, ext. 214	8:30 am - 4:30 pm Monday thru Friday	
Huron Street Woman’s Center 923 Huron Street Toledo, OH 43604 (419) 242-6028 <u>OB/GYN ONLY</u>	OB/GYN ONLY Appt., ext. 11 Social Service, ext. 11	OB and Women’s Health 8:30 – 4:30 pm	
NHA Pediatrics 1 Aurora Gonzalez Dr. Toledo, OH 43609 (419) 241-4230	Pediatrics Appt., ext. 200 WIC, ext. 208	8:30 am – 5:00 pm Mon. – Fri. Call for appointment	
Daisy Smith Peds 430 Nebraska Ave. Toledo, OH 43604 (419) 255-7883	Pediatrics Appt., ext 100 WIC ext 108	Call for appointment Mon. – Fri.	
St Luke’s Hospital Family Medicine Center 6005 Monclova Road Monclova, OH 43537 (419) 893-5959 Fax: (419) 893-5918	Family Medicine Prenatal/OB-GYN Pediatrics	8:30 AM – 5:00 PM Mon. – Fri.	St Luke’s Hospital Family Medicine Center 6005 Monclova Road Monclova, OH 43537 (419) 893-5959 <i>Not enrolling new members at this time</i>

SUBJECT TO CHANGE

Toledo/Lucas County CareNet Primary Care Healthcare Providers, Services, Hours, Enrollment Information

CARENET IS NOT A HEALTH INSURANCE ● CARENET IS ONLY VALID AT PARTICIPATING LOCATIONS
SUBJECT TO CHANGE ● Updated 11/23/09

HEALTHCARE PROVIDERS	SERVICES	DAY OF WEEK/HOURS	ENROLLMENT SITE
Health Department Downtown Clinic 635 N. Erie Street Toledo, OH 43624 (419) 213-4203	Pediatric Primary Care	Mon – Wed & Fri	Health Department Downtown Clinic 635 N. Erie Street (419) 213-4203
	Adult Primary Care	8:00 am – Noon Mon-Fri	
	OB/Prenatal	8:00 am – 4:45 pm Thur	
Western Lucas County Clinic 330 Oak Terrace Blvd. Holland, OH 43528 (419) 213-6255	OB/Prenatal	8:00 am – 4:45 pm Tues	Western Lucas County Clinic 330 Oak Terrace Blvd. (419) 213-6255
	Family Practice	8:00 am – 4:45 pm Mon-Wed & Fri	
The Center for Health Services 2150 West Central Avenue Toledo, OH 43606 (419) 291-8542 Not enrolling new members at this time	Pediatric Primary Care Adult Primary Care OB/Prenatal/ GYN/Specialty Clinics	8:00 am – 4:30 pm Mon - Fri	The Center for Health Services 2150 West Central Ave. (419) 291-8542 Not enrolling new members at this time
W.W. Knight Family Practice Ctr 2051 West Central Avenue Toledo, OH 43606 419-291-2051 Not enrolling new members at this time	Family Practice	8:00 am – 4:30 pm Mon - Fri	
HEALTHCARE PROVIDERS	SERVICES	DAY OF WEEK/HOURS	

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HEALTHCARE PROVIDERS	SERVICES	DAY OF WEEK/HOURS	ENROLLMENT SITE
Navarre Family Medical Assoc. 2702 Navarre Avenue, Suite 206 Oregon, OH 43616 (419) 696-6000 Not enrolling new members at this time	Family Practice	9:00 AM – 12:00 PM 1:00 PM – 5:00 PM Mon, Tues, Thur & Fri 1:00 PM – 5:00 PM Wed	Mercy Healthcare Center 2200 Jefferson Avenue Toledo, OH 43624 Call (419) 251-4000 for an appointment
Navarre Park Clinic 1020 Varland Toledo, OH 43605 (419) 696-1515 Family Practice (419) 696-1520 Obstetrics Not enrolling new members at this time	Family Practice & Obstetrics	9:00 am – 5:00 pm Mon - Fri 9:00 am – 8:00 pm Wednesday (OB Only)	Not enrolling new members at this time
Mercy Family Practice 2200 Jefferson Avenue Toledo, OH 43624 (419) 251-1400 Not enrolling new members at this time	Family Practice	9:00 AM – 5:00 PM Mon - Fri	
Family Care Center-Adult Clinic 2213 Franklin Avenue Toledo, OH 43620 (419) 251-2360 Not enrolling new members at this time	Adult Primary Care	9:00 AM – 5:00 PM Mon - Fri	

SUBJECT TO CHANGE

FINANCIAL ASSISTANCE APPLICATION

OFFICE USE ONLY

CareNet# _____	% of Co-Pay _____	H-Cap _____	Medical Home _____
Charity _____	Start Date _____	End Date _____	

Patient's Name _____	Applicant Name _____
Patient's SS# _____	(if different from patient) Patient's DOB _____
Address _____	City _____ State _____ Zip _____
Phone # _____	Alternate Phone # _____
Spouse's Name _____	Spouse's DOB _____
Spouse's SS# _____	

Have you been a Lucas County resident for the past 6 months? Yes No
United States Citizen? Yes No
 Patient's Primary Care Physician _____
 Spouse's Primary Care Physician _____

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow/widower
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female If female & over 40 are you enrolled in BCCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a U.S. Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive VA Benefits: : <input type="checkbox"/> Yes <input type="checkbox"/> No

Optional:

Ethnicity: Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other _____
Primary Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____

Provide information for ALL people in your immediate family who live in your home

*If zero (0) income is reported, explain how patient is supporting self _____

*Number of people in your family: _____ If you need more space, please attach a separate sheet

Name	DOB	Relationship to patient	Adopted, Natural, Step-child	Current gross monthly income	Type of income**	Gross income 3 months prior to date of service	Gross income 12 months prior to date of service
				\$		\$	\$
				\$		\$	\$
				\$		\$	\$
				\$		\$	\$
				\$		\$	\$

**Types of income included are: wages, self employment, social security, unemployment, child support, alimony, workers' comp., pension, VA benefits, OWF, etc.

*Provide income verification with application. Income verification may include: pay stubs, 1040 IRS tax forms, W-2's, self employment records, award letter, bank statement, etc.

PLEASE LIST ALL CURRENT EMPLOYERS

Are you currently employed? Yes No

Patient Current Employer(s) & Phone #(s) with start date(s) : _____

All Patient's Previous Employers in past 12 months (please list beginning and end dates):

All Spouse Employer(s) in the past 12 months (please list beginning and end dates): _____

2) **Have you applied for Medicaid or Disability Assistance?** Yes No.....if Yes,
What were the results? _____ Billing # _____

3) **Do you have health insurance (other than Medicaid)?** Yes No.....if Yes,
List type of insurance _____ Policy # _____ Group# _____

4) **Do you now, or have you in the past, had a workman's comp claim?** Yes No If Yes,
Date _____ Claim # _____ Medical Problem _____

Are you still receiving benefits Yes No Medical Treatment _____

5) Where you an Ohio resident at the time of hospital service Yes No

6) **Please indicate if any of the outstanding medical bills with our facilities are due to a Motor Vehicle accident or due to Liability?** Yes No.....if Yes, please complete the following section:

Name of Auto Insurance _____

Insurance Address _____

Policy Number _____

Insurance Agent's Name/Phone _____

Name of person liable for accident _____

7) **Do you have assets over \$10,000** such as savings, checking, home equity, stocks, bonds, 401, IRA, CD's, etc?

Yes No If Yes, list type and amount _____

I understand any financial assistance provided may be reversed if it is determined this information is not correct.

“Providing false information to induce another to extend credit or to bestow any other valuable benefit may be a violation of the Ohio Revised Code Section 2921.13”.

By my signature below, I affirm the information on this application is true to the best of my knowledge.

Signature of patient Date Signature of spouse Date

Signature of enrollment coordinator Date

I have read and understand the **Notice of Privacy Practice:** Yes No