



## Information and Application

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The goal of the Toledo/Lucas County CareNet 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 preventive and 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 (Medicare, Medicaid, CHIP, veteran's benefits, etc.).
- You are not eligible for or do not have any other form of health insurance coverage.
- Your household size and annual income (as reported on your most recent tax return) is in the following ranges:
  - Household of 1 up to \$24,280
  - Household of 2 up to \$32,920
  - Household of 3 up to \$41,560
  - Household of 4 up to \$50,200
  - Household of 5 up to \$58,840

### To Apply

Fill out as much of the attached Healthcare Financial Assistance Application as you can and collect a copy of the required documents listed below. Then follow these steps:

1. Choose your healthcare provider from the list that begins on the next page. If you already have a family doctor, check to see if he/she is willing to see you as a CareNet member. If so, call 419-842-0800 for instructions on how to enroll.
2. Follow instructions on enrolling for the clinic you have selected. Each clinic has their own enrollment process.
3. As soon as you are considered eligible, you will be enrolled.

### To enroll in CareNet, you must provide the following documents:

- Completed Financial Assistance Application.
- Income verification: including – tax returns, pay stubs, W-2's, self-employment records, award letter, bank statements or other documents containing income information. (Please do not submit originals as they will not be returned).
- Proof of residency: such as a driver's license.

CARENET IS NOT HEALTH INSURANCE ● CARENET IS ONLY VALID AT PARTICIPATING LOCATIONS ● SUBJECT TO CHANGE ● Updated 12.12..2018

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

HEALTHCARE PROVIDERS	SERVICES	DAY OF WEEK/HOURS	CLINIC INFORMATION
<b>Cordelia Martin Community Health Center &amp; Daisy Smith Pediatrics</b> 615 Divison St (Behind Jones Leadership Academy) Toledo, OH 43604 (419) 255-7883	Adult Primary Care Dental Care Social Services	8am – 4:30 pm Monday - Friday	<b><u>Each clinic:</u></b> <b>Please call the location you wish to be seen at and ask to schedule a new patient appointment. Please take your application with required documentation to that appointment and provide it to the social worker.</b>
<b>Nexus Health Care</b> 1415 Jefferson Ave. Toledo, Ohio 43604 (419) 214-5700	Adult Primary Care OB- GYN Dental Cary Pharmacy Social Service	8:00 am – 4:30 pm Monday - Friday	
<b>Southside Community Health Center</b> 732 South Avenue Toledo, OH 43609 (419) 241-6106	Adult Primary Care Pediatric Primary Care Social Services	8:00 am – 4:30 pm Mon., Tues., Weds., Fri (Adults)  1pm – 4:30pm Tues & 8am – 11:45 am Thurs (Pediatric Primary Care)	
<b>Holland Health Care</b> 225 S Irwin Rd Holland, OH 43528 567-703-8985	Family Practice (Adults, Women’s, Pediatric) Social Services	8am -4:30pm Monday - Friday	
<b>Navarre Park Clinic</b> 1020 Varland Toledo, OH 43605 (419) 696-1515 Family Practice (419) 696-1520 Obstetrics	Family Practice Obstetrics Pediatric	8:00 am – 4:300 pm Monday - Friday	
<b>Compassion Health Toledo</b> 1638 Broadway Toledo, Ohio 43609 567-661-0565	Family Practice Women’s Health Prenatal Care Pediatric Care Childhood Vaccines	8:00 am – 4:00 pm Monday – Friday  Limited walk-in appointments available	

<p><b>East Toledo Community Health Center - Health Partners of Western Ohio</b>                  2020 Starr Avenue                  Toledo, OH 43605                  567-218-1900</p>	<p>Pediatrics                  Adult Primary Care                  Woman's Health                  Chronic Disease Management                  Clinical Pharmacy                  Childhood Vaccines                  Behavioral Health                  Substance Abuse Treatment</p>	<p>8:00 am – 4:30 pm                  Monday – Friday                   **WALK-IN APPOINTMENTS AVAILABLE</p>	<p><b>Please call this location &amp; ask to schedule a new patient appointment. Please take your application with required documentation &amp; give to the receptionist.</b></p>
<p><b>The Center for Health Services</b>                  2150 West Central Avenue                  Toledo, OH 43606                  (419) 291-8542</p>	<p>Pediatric Primary Care                  Adult Primary Care                  OB/Prenatal/                  GYN/Specialty Clinics</p>	<p>8:00 am – 4:30 pm                  Monday - Friday</p>	<p><b>Please call and ask to schedule a new patient appointment. Please take your application with required documentation to that appointment and provide it to the &amp; give to the receptionist.</b></p>

<p><b>Mercy Family Practice</b>                  2200 Jefferson Avenue                  Toledo, OH 43624                  (419) 251-1400</p>	<p>Family Practice</p>	<p>9:00 am – 5:00 pm                  Monday – Friday</p>	<p><b><u>Each clinic:</u></b>                  Please call the location you wish to be seen at and ask to schedule a new patient appointment. <b>Prior to your first appointment, call 419-251-5966 to make another appointment to enroll in CareNet.</b></p>
<p><b>Navarre Family Medical Associates</b>                  2702 Navarre Avenue                  Suite 206                  Oregon, OH 43616                  (419) 696-6000</p>	<p>Family Practice</p>	<p>9:00 am – 12:00 pm                  1:00 am – 5:00 pm                  Mon., Tues., Thurs. &amp; Fri</p> <p>1:00 pm – 5:00 pm                  Wednesday</p>	
<p>Family Care Center                  2213 Franklin Avenue                  Toledo, Ohio 43620                  419-251-2360</p>	<p>Adult Primary Care</p>	<p>9am – 5pm                  Monday - Friday</p>	

<p><b>Family Medical Center of Michigan, Inc.</b>                  8765 Lewis Ave.                  Temperance, Mi 48182                  734-847-3802 (Medical)                  734-850-6920 (Dental)</p>	<p>Primary Care                  Dental                  OB/GYN                  Behavioral Health</p>	<p>Medical:                  8:00 am – 5:00 pm                  Monday, Tuesday, Friday</p> <p>8:00 am – 8:00 pm                  Wednesday, Thursday</p> <p>Dental:                  8:00 am – 5:00 pm                  Monday</p> <p>8:00 am – 6 pm                  Tuesday – Friday</p>	<p><b>Please call this location &amp; ask to schedule a new patient appointment. Please take your application with required documentation &amp; give to the receptionist.</b></p>
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<p><b>St. Luke’s Family Medicine Center</b>  <b>7045 Lighthouse Way</b>  <b>Perrysburg, OH 43551</b>  <b>419-873-6836</b></p>	<p>Family Medicine                  Prenatal Care                  Pediatrics                  OB/GYN                  Adult Primary Care                  Obstetrics                  Childhood Vaccines                  Behavioral Health</p>	<p>8:00 am – 5:00 pm                  Monday, Tuesday, Wednesday and Friday</p> <p>Thursday 8:00am - Noon</p> <p>.  <b>**WALK-IN APPOINTMENTS AVAILABLE</b></p>	<p>Please call this location &amp; ask to schedule a new patient appointment. Please take your application with required documentation to that appointment and provide it to the receptionist</p>
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CareNet Fax# 419-842-0999  
**FINANCIAL ASSISTANCE APPLICATION**

**OFFICE USE ONLY**

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

Patient's Name _____	Applicant Name _____ (if different from patient)
Patient's SS# _____	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

**Patient's Primary Care Physician:** \_\_\_\_\_    **Clinic Name:** \_\_\_\_\_

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

Optional:

<b>Ethnicity:</b> Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Race:</b> <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 _____
<b>Primary Language Spoken:</b> <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**

1) 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) Were 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

\_\_\_\_\_  
**Medicaid Application Confirmation Number**

\_\_\_\_\_  
**Date of Medicaid Application**