NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

Primary Care Access Plan / Behavioral Health Access Plan Application

June 2024

The Primary Care Access Plan (PCAP) and Behavioral Health Access Plan (BHAP) are provided to you by North Carolina Health and Human Services, Office of Rural Health state funds. The Access Plans will cover many medically necessary services provided by your medical practice. A full list of services is available upon request. If eligible, enrolled participants are covered for one year from approval date or until a change in their economic or insurance status. Participants must recertify for this program annually and inform the practice of any changes to economic or insurance status.

Patients may receive one free PCAP/ BHAP visit without approval, for additional visits, approval is required.

Patient completes all sections below. Support in completing the application may be provided by the SDRHC.

Applicant Information

_____

First Middle Initial Last

Current Address

_____

Street Address/P.O. Box City Zip

Telephone # or # where applicant can be reached during the day _____

Date of Birth (_____/_____/_____)

Social Security # (if applicable)_____

Applicant status: (Check status)

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Race: (Check all that apply)

American Indian or Alaska Native ☐ Asian ☐ African American ☐

Native Hawaiian or Pacific Islander ☐ White ☐ Prefer not to report ☐

Ethnicity: (Check yes or no) Hispanic/Latino ***Yes*** ☐ ***No*** ☐

Language Preference: (Check or List one) English ☐ **Spanish** ☐ **Other** _____

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****Please complete the below table and include information of individual and or family members applying.**

Family Size:

- You
- Your spouse
- Your children under 21 including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

Do not include:

- Your parents who live with you, but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return
- If someone in your family is pregnant, do not include the unborn child in your family size on this page

Name	**Age**	**Is this person a patient?**	***FOR OFFICE USE*** **Is this individual eligible for the PCAP/BHAP Program?**

FAMILY INCOME - List income earned by you and/or anyone else that contributes to your household. Income includes wages, tips, salary received. Attach any supporting documents. Put 0 if not applicable.

Calculating Gross Amount: If you or anyone in your family receives benefits or deductions, use the income amount given BEFORE deductions or benefits are taken out of pay.

Name(s) of Family Members	**How often paid? Monthly, weekly, etc.**	**Gross Amount (before taxes or deductions)**
	TOTAL	0.00

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FAMILY BENEFITS - Income such as Social Security, Unemployment benefits, retirement benefits, child support, private or employer sponsored disability etc. Provide copies of any pay stubs, award letters, or other proof of this income. *Put 0 if the patient does not have any benefits.*

Name of Family Member Receiving	List where income is from (i.e. child support, social security, unemployment, etc.)	How often received? Monthly, weekly, etc.	Gross Amount
		TOTAL	0.00

Name of Family Member Paying	List of deduction Type (i.e. child support, alimony, etc.)	How often does the Family Member pay?	Amount
		TOTAL	0.00

DEDUCTIONS – Included deductions must support or pay for a dependent. Practice may request proof of resources through documentation, but it is not required by NC ORH. *Put 0 if you do not have any resources.*

TOTAL GROSS INCOME	0.00
TOTAL DEDUCTIONS	0.00
OVERALL TOTAL	0.00

What is included in the calculations above?

- **Total Gross Income = Total Income + Total Benefits**
- **Total Deductions = Total Deductions (if provided)**
- **Overall Total = Total Gross Income – Total Deductions (if provided)**

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Comments/Additional Information: Please use this section to detail or provide an explanation of anything that could not be included in the application above.

Applicant's Acknowledgement

- I either read or had read to me all parts of this application and I understand my rights and responsibilities as an applicant/recipient. Rights and Responsibilities are on the last page of this application.
- I authorize the release of any information necessary to establish my eligibility. This release is good for one year from the date of this application.
- This authorization to release information may be reproduced.
- All information I give is confidential.
- I attest that all statements recorded on this document are true and correct to the best of my knowledge.

Applicant's Signature_____ **Date** _____

Signature of Screening Provider Completing Form _____ **Title** _____

Printed/Typed Name of Provider Completing Form_____

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"Your Rights and Responsibilities"

Rights:

- Apply for assistance and, if found ineligible, may reapply at any time.
- Not be discriminated against because of race, color, national origin, sex, religion, age or disability.
- Have the information you provide kept in confidence.
- Ask for help with medical transportation, if found eligible for Primary Care Access Plan/Behavioral Health Access Plan Program. If transportation is provided, it will be to the nearest appropriate medical provider of your choice, by the least expensive method. To request transportation assistance, contact your county department of social services.
- Withdraw from the program at any time.
  - Appeal to the North Carolina Office of Rural Health if:
    - ➢ You were denied the right to apply for assistance.
    - ➢ You were encouraged to withdraw your application.
    - ➢ Your application was denied, and you believe the decision is incorrect.

Responsibilities*:*

- I agree to provide all necessary information to help the provider to determine my eligibility.
- I agree to notify the provider of any changes in my address, plans to move, availability of other health insurance, or if I no longer want to receive treatment from this provider.
- I certify that the information I have provided is a true and complete statement of facts. I understand that State and Federal law provide for fines, imprisonment, or both for any person who withholds or gives false information to obtain assistance.
- I certify I currently live in North Carolina.
- I understand that the individuals listed on page one (1) are responsible for paying the lessor of actual charges or a copayment of ___ to the medical practice for covered PCAP/BHAP services.
- I agree to notify the medical practice of any changes affecting the size or income of my Family Size.
- Enrolled Family members will participate in this program until the renewal date unless there are changes in my Family Size or income.

Applicant Signature: _____

Date: _____

Staff Signature: _____ Date: _____

Mail Completed form to:

Scotland Health MAP Plan
Attn: Anna/Amanda
205 Lauchwood Drive, Suite C
Laurinburg, NC 28352