NCACCH | North Coast Aboriginal Corporation for Community Health

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★ IMPORTANT NOTICE ★

DO YOU HAVE THE NEW "BLUE" NCACCH HEALTH ACCESS CARD?

If you haven't, please complete and return this form to NCACCH
as soon as possible to receive your 2016-2018 Health Access Card

Dear NCACCH Client/Families

To ensure we have current information for you/your family on your new card, please complete the form on the back of this letter and return to NCACCH as soon as possible (your card may take 3-4 weeks to be issued).

★ Note: If you've never had a NCACCH Health Access Card
(please do not complete this form)
Contact a NCACCH Referrer to complete a Health Access Card Application.

Please list and print the full name of all eligible family members and their Medicare number. If your partner or child has a separate Medicare number, please note their number against their name. Babies up to 6 weeks of age can be added to this form, anyone older will need to see a NCACCH Referrer to be added to you card.

If you have a child/children 18 or over who is still listed on your card, or a child that has left home and is living independently, please ask them to contact NCACCH or see a Referrer for a form of their own.

The eligibility criteria for a NCACCH Health Access Card is:-

* ***Aboriginal and/or Torres Strait Islander persons who have resided in the NCACCH service area for at least 3 months.***
* ***Non-Indigenous biological parents with dependent Aboriginal and/or Torres Strait Islander children – no other non-Indigenous family members are to be included on the card.***
* ***Aboriginal and/or Torres Strait Islander persons over the age of 18 years are eligible for a card in their own right and will not be incorporated as a dependent on a family card.***

Please Note: We have added a question to the form (on the back) asking if you are registered for Closing the Gap (CTG) -
The Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment Measure improves access to PBS medicines/scripts for eligible Aboriginal and Torres Strait Islanders who are living with, or at risk of, chronic disease. Closing the Gap prescriptions attract a lower or nil patient co-payment for PBS medicines/scripts.
CTG is not connected to your NCACCH Health Access Card - your GP registers you for CTG.

Any person that uses the services of NCACCH has the right to make a complaint. If you are dissatisfied with the service received from NCACCH; Staff and Referrer's will ensure that you are fully aware of the complaints process. A copy of the privacy policy is available on our website www.ncacch.org.au

If you are unsure, have a question or would like help to complete the form please contact NCACCH on 5443 3599.

Kind regards

Kim Helmore
General Manager

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"Your Pathway to Better Health"

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Health Access Card Number			

HEALTH ACCESS CARD – UPDATE DETAILS FORM

CLIENT DETAILS: *(Please print clearly)*

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Expiry Date _____/_____

First Name: _____ Middle Name:_____ Surname: _____

Date of Birth: _____ Male / Female Aboriginal / Torres Strait Islander / Non Indigenous Biological Parent

Phone 1: _____ Phone 2: _____ I agree to receive SMS Yes / No

Address: _____Suburb:_____Postcode:_____

Postal Address (if different from above):_____

Email Address:_____

Please Note: NCACCH will be using your email to communicate with you

Client Smoking Status: *Smoker* ☐ *Non Smoker* ☐

★ Note: Only a Non-Indigenous Biological Parent with dependent Aboriginal and/or Torres Strait Islander child/children (under 18) are eligible for a Health Access Card.

Please list below Aboriginal and/or Torres Strait Islander dependants and/or Non-Indigenous Biological Parent to be included on your NCACCH Health Access Card (please print clearly to avoid errors on your card).

Registered for Closing the Gap			Medicare Extension Number	First Name	Middle Name	Surname	Male/Female	Date of Birth	Aboriginal	Torres Strait Islander	Non Indigenous
Yes	No	Unsure									

(If adding a partner or dependant older than 6 weeks of age, you will need a NCACCH Referrer to sign here)

NCACCH REFERRER: _____ SIGNED: _____ DATE: _____

**** Please tick box to "Agree"

☐ CONFIDENTIALITY STATEMENT

For NCACCH to continue delivering quality health *care* to our NCACCH clients, it is important for us to collect data. If you agree we may forward de-identified information about you to funding bodies and other stakeholders. This information ***will not*** include your name or address. The information will be treated in confidence and will only be used for research purposes, to assist in planning and evaluating the *Brokerage Model.* Your decision to release, or not release information, will not affect your access to services in any way. However, if you do agree to release this information, it will assist with future NCACCH service provision.

☐ ELIGIBILITY

The information I have given on this form is true and correct and I have read and understand the NCACCH Eligibility Guidelines (on the back). I understand that I may be asked to provide additional information to confirm my eligibility to receive services. If I am unable to provide documentation I am aware that I may be declined access to future NCACCH services.

NAME: _____ SIGNED: _____ DATE: _____

☐ Client Declined Consent