NCACCH North Coast Aboriginal Corporation for Community Health

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★ IMPORTANT NOTICE ★

DO YOU HAVE THE NEW (DARK BLUE) HEALTH ACCESS CARD?

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

Dear NCACCH Client/Families

We are preparing to print new Health Access Cards for all registered NCACCH clients. 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.

★ 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.***
* ***A non-Indigenous biological parent, with dependant Aboriginal and/or Torres Strait Islander child/children under the age of 18***

***** Please note - Other non-Indigenous family members are not eligible to be included on the 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 5346 9800.

Kind regards

John Spink
Chief Executive Officer

"Your Pathway to Better Health"

NCACCH HEALTH ACCESS CARD UPDATE DETAILS FORM

HEALTH ACCESS CARD NUMBER			

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

(TO AVOID ERRORS ON YOUR CARD, PLEASE PRINT CLEARLY IN UPPER CASE)

	FIRST NAME	MIDDLE NAME	SURNAME	MALE / FEMALE	DATE OF BIRTH	ABORIGINAL	TORRES STRAIT ISLANDER	OTHER	MEDICARE NUMBER & EXTENSION		REGISTERED FOR CLOSING THE GAP		SMOKER	
1	PRIMARY CARD HOLDER										YES	NO	YES	NO
2														
3														
4														
5														
6														
7														
8														
9														
10														

RESIDENTIAL ADDRESS	SUBURB	POSTCODE
POSTAL ADDRESS (if different from above)	EMAIL ADDRESS	
PHONE 1	PHONE 2	I AGREE TO RECEIVE SMS YES / NO

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.

☐ AGREE TO CONSENT ☐ DECLINED CONSENT

☐ 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:______________________