NCACCH | North Coast Aboriginal Corporation for Community Health

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★ IMPORTANT NOTICE ★

IF YOU HAVE NOT RECEIVED YOUR NEW BROWN NCACCH HEALTH ACCESS CARD PLEASE COMPLETE & RETURN THIS FORM AS SOON AS POSSIBLE

Dear NCACCH Client/Families

We wish to advise that we are currently issuing 2014-2015 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 to avoid any delay in services

★ Note: If you've never had a NCACCH Health Access Card
(do not complete this form)
Please 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.

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.***

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

Kind regards

Like us on Facebook

Kim Helmore
Operations Manager

"Your Pathway to Better Health"

NORTH COAST ABORIGINAL CORPORATION FOR COMMUNITY HEALTH

Health Access Card – Update Details Form

First Name: _____ Middle Name:_____

Surname: _____ Date of Birth: _____ Gender: [M] [F]

Address: _____

Suburb: _____ Post Code: _____

Postal Address (if different from above):_____

Email Address:_____

Phone: _____ Mobile: _____

Aboriginal [ ] Torres Strait Islander [ ] Non Indigenous Biological Parent [ ]

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

MEDICARE CARD NUMBER: ☐☐☐☐☐☐☐☐☐☐ Exp Date ☐☐☐☐

HEALTH ACCESS CARD NUMBER: ☐☐☐☐

★ Note: Only Non-Indigenous Biological Parents with dependent Aboriginal and/or Torres Strait Islander child/children are eligible for a Health Access Card

List 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)

Medicare Id Number	First Name	Please print full Middle Name	Surname	M / F	Date of Birth	Aboriginal	Torres Strait Islander	Non Indigenous

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

NCACCH REFERRER:_____**DATE:**_____

***** Please tick box to "Agree"*

☐ **RELEASE OF CONFIDENTIAL INFORMATION 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. You are able to access your personal information at any time during NCACCH office hours.

☐ **ELIGIBILITY**

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

Name: _____ Signed: _____ Date: _____

☐ Client Declined Consent