NCACCH | North Coast Aboriginal Corporation for Community Health

NCACCH HEALTH ACCESS CARD UPDATE DETAILS FORM

HEALTH ACCESS CARD NUMBER			

Please list below Aboriginal and/or Torres Strait Islander dependants and/or <u>Non-Indigenous Biological Parent</u> 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 ***<u>will not</u>*** 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:** _____