NCACCH | North Coast Aboriginal Corporation for Community Health

HEALTH ACCESS CARD UPDATE DETAILS FORM

1. PLEASE TICK BOX/BOXES TO INDICATE UPDATE REQUIRED			
	Replacement of a Health Access Card (Complete section 2, 3, 6)		Adding a partner/ dependant (Complete section 2, 6, 7)
	Notice of deceased person (Complete section 2, 4, 6)		Removal of partner/ dependant (Complete section 2, 6, 8)
	Change of contact details (Complete section 2, 5, 6)		Eligible for an independent card – 18 years of age (Complete section 2, 5, 6, 7)

2. HEALTH ACCESS CARD NUMBER					If you do not have a current HAC, do not proceed. Contact an NCACCH Referrer to complete an application.

3. REPLACEMENT of a LOST or STOLEN			
Identify the reason for replacement			Stolen
	Lost		Original not received (complete section 5)

4. NOTICE OF DECEASED PERSON	
Full Name of the deceased:	Date of Birth (if known):
Notified By (Name):	Relationship to deceased:

5. CONTACT DETAILS		
Residential address:	Suburb:	Postcode:
Postal address: (if different from above)	Suburb:	Postcode:
Email address:	Telephone: 07	Mobile: 04

6. CONFIDENTIALITY STATEMENT and ELIGIBILITY

By signing this form, I agree, NCACCH may forward de-identified information about me to funding bodies and other stakeholders. This information will not include my 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. My decision to release, or not release information, will not affect my access to services in any way. I understand that agreeing to release this information, will assist with future NCACCH service provisions and I can access my personal information at any time during NCACCH office hours.

By signing this form, I agree the information provided is true and correct and the NCACCH Referrer has explained to me the NCACCH Eligibility guidelines. 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.

NCACCH communicates program updates and general communication through SMS. I agree to receive SMS:	**YES**	**NO**

Name:	Signature:	Date:

REFERRER ONLY		
Name:	Signature:	Date:

NCACCH OFFICE USE ONLY		
Entered by:	Receipt No (if applicable):	Date:

T: 07 5346 9800
F: 07 5346 9899

E: admin@ncacch.org.au
P: PO BOX 479 Cotton Tree Q 4558

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7. FAMILY and HEALTH ACCESS CARD DETAILS (TO AVOID ERRORS ON YOUR CARD, PLEASE PRINT CLEARLY IN UPPER CASE)

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.

THE INFORMATION RECORDED WITHIN THIS FORM MATCHES THAT OF THE MEDICARE CARD

	FIRST NAME	MIDDLE NAME	SURNAME	MALE/ FEMALE/OTHER	DATE OF BIRTH	ABORIGINAL	TORRES STRAIT ISLANDER	ABORIGINAL & TORRES STRAIT ISLANDER	NON-INDIGENOUS – BIOLOGICAL/ PARENT	MEDICARE NUMBER & EXTENSION		REGISTERED FOR CLOSING THE GAP		CURRENTLY SMOKING	
												YES	NO	YES	NO
1															
2															
3															
4															
5															
6															
7															

8. REMOVAL of PARTNER and/or DEPENDANT

	FULL NAME	DATE OF BIRTH	REASON FOR REMOVAL
1			
2			
3			
4			

NOTICE - PRIVATE AND CONFIDENTIAL

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