INITIAL CERTIFICATION FORM

General Information and Instructions

1. **What is Take Care Recovery Plan ("TCRP")?:** TCRP is an offer by Take Care Clinics to provide qualified unemployed, uninsured individuals and their qualifying family members with FREE limited primary health care and diagnostic testing services available at Take Care Clinics. TAKE CARE RECOVERY PLAN IS **NOT** INSURANCE, **NOT** A MEDICAL DISCOUNT PLAN, AND **NOT** A HEALTHCARE DISCOUNT PROGRAM. PLEASE SEE THE TERMS AND CONDITIONS FOR COMPLETE DETAILS (available at www.takecarerecoveryplan.com or upon request at any Take Care Clinic).

2. **Who Qualifies for TCRP?:** TCRP is available to uninsured Terminated Persons and their uninsured Dependents (collectively "Family Member(s)"). Only those persons who **DO NOT** have any health care coverage or health insurance of any type qualify for TCRP offer.

   You are a Terminated Person if:
   (1) you are 19 years old or older;
   (2) you were terminated from employment on or after March 31, 2009;
   (3) you are receiving, or will receive, federal or state unemployment benefits and can provide proper verification to Take Care Health Systems within 21 days of the date of this *Initial Certification Form*;
   (4) you **DO NOT** have any health care coverage or health insurance of any type; and
   (5) you, your spouse/same-sex domestic partner, your dependent child (18 months through 18 years of age) or your spouse/same-sex domestic partner's dependent child (18 months through 18 years of age) received services at a Take Care Clinic prior to the date of your employment termination.

   You are a Terminated Person's Dependent if:
   (1) you are:
   (a) the Terminated Person's spouse/same-sex domestic partner;
   (b) the Terminated Person's child (18 months through 18 years of age); or
   (c) you are the child (18 months through 18 years of age) of the Terminated Person's spouse/same-sex domestic partner; and
   (2) you **DO NOT** have any health care coverage or health insurance of any type.

3. **How to Qualify; Initial Certification Process.** To initially qualify for the TCRP offer for yourself and/or any potential Family Members, you must, prior to or at the first visit of a potential Family Member to a Take Care Clinic to take advantage of the TCRP offer, complete this *Initial Certification Form* and submit it along with:

   (1) a copy of a valid Driver's License or State-Issued Identification Card for all adults who desire to participate; and
   (2) a copy of the government-issued determination letter evidencing that the Terminated Person is entitled to federal or state unemployment benefits resulting from a termination of employment on or after March 31, 2009. You may submit the *Initial Certification Form* in advance of the *d*etermination letter. However, you must submit the determination letter within 21 days of the date you submit this *Initial Certification Form* in order to qualify for the TCRP offer.

   Please be aware that at each subsequent patient visit to a Take Care Clinic, the Terminated Person or his or her spouse/same sex domestic partner must recertify the qualifications of the Family Members to participate in the TCRP offer by completing a TCRP *Patient Visit Form (Subsequent Visit)* and submitting it along with acceptable evidence that the Terminated Person has received unemployment benefits within the 30 day period preceding the date of such subsequent visit (e.g. a copy of the unemployment benefit payment stub).

4. **Where Do I Send Completed Forms and Supporting Documentation?:** Please fax or mail this *Initial Certification Form* and all supporting documentation to:

Take Care Health Systems
Attention: Take Care Recovery Plan
4165 30th Avenue South – Suite 101
Fargo, ND 58104-8419
FAX #: 1-866-656-8518

Today's date (MM/DD/YYYY): / /

PARTICIPATION INFORMATION AND QUALIFICATION VERIFICATION

TO BE COMPLETED BY THE TERMINATED PERSON
OR HIS OR HER SPOUSE/SAME SEX DOMESTIC PARTNER
ON BEHALF OF ALL FAMILY MEMBERS

(Please Print)

Please check appropriate responses.

1. PLEASE IDENTIFY YOUR AGE:

ARE YOU 19 YEARS OF AGE OR OLDER?

❑ YES If *YES* please proceed to next question.

❑ NO If *NO* please **STOP**; **you are not qualified to complete this Initial Certification Form**.

2. PLEASE CONFIRM LOSS OF EMPLOYMENT

WERE YOU (OR YOUR SPOUSE/SAME-SEX DOMESTIC PARTNER) TERMINATED FROM EMPLOYMENT ON OR AFTER MARCH 31, 2009?

❑ YES If *YES* please provide following: Date of Termination: ____________________________

Terminating Employer:___________________________

❑ NO If *NO* please **STOP**; **the Terminated Person and all related parties DO NOT qualify for TCRP.**

3. PLEASE IDENTIFY WHO YOU ARE:

❑ The Terminated Person.

❑ The Spouse/Same Sex Domestic Partner of the Terminated Person.

TERMINATED PERSON:

	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY): / /	Social Security# (XXX-XX-XXXX):
Street Address:					
City:	State:	ZIP Code:		Home Phone # (XXX-XXX-XXXX):	Cell Phone # (XXX-XXX-XXXX):
Prior Health Coverage Provider Name:		**ID Number:**		**Group Number:**	

SPOUSE/SAME-SEX DOMESTIC PARTNER:

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY): / /	Social Security# (XXX-XX-XXXX):
Street Address (If Different):					
City:	State:	ZIP Code:		Home Phone # (XXX-XXX-XXXX):	Cell Phone # (XXX-XXX-XXXX):
Prior Health Coverage Provider Name:		**ID Number:**		**Group Number:**	

4. <u>PLEASE CONFIRM UNEMPLOYMENT BENEFIT STATUS</u>

IS THE TERMINATED PERSON ELIGIBLE FOR FEDERAL OR STATE UNEMPLOYMENT BENEFITS?

❑ YES — If *YES* please proceed to next question.

❑ NO — If *NO* please STOP; **the Terminated Person and all related parties DO NOT qualify for TCRP**.

IS THE TERMINATED PERSON CURRENTLY RECEIVING UNEMPLOYMENT BENEFITS?

❑ YES — If *YES* please attach a copy of the government issued determination letter stating that the Terminated Person qualifies for unemployment benefits. If the Terminated Person does not currently have a copy of the government issued determination letter in his or her possession, the Terminated Person must submit the letter to Take Care Health Systems within 21 days of submitting this completed Initial Certification Form. In the event the Terminated Person fails to submit the government issued determination letter within 21 days, then the Terminated Person and all related parties **DO NOT QUALIFY FOR TCRP AND MUST PAY FOR ALL SERVICES RECEIVED AT THE TAKE CARE CLINIC**.

❑ NO — If *NO* please proceed to next question.

HAS THE TERMINATED PERSON APPLIED FOR UNEMPLOYMENT BENEFITS BUT IS STILL WAITING FOR A GOVERNMENT DETERMINATION THAT THE TERMINATED PERSON QUALIFIES FOR UNEMPLOYMENT BENEFITS?

❑ YES — If *YES* please provide the date of application: ______________________. If the Terminated Person does not currently have a copy of the government issued determination letter, the Terminated Person must submit a copy of the determination letter to Take Care Health Systems within 21 days of submitting this completed Initial Certification Form. In the event the Terminated Person fails to submit the government issued determination letter within 21 days, then the Terminated Person and all related parties **DO NOT QUALIFY FOR TCRP AND MUST PAY FOR ALL SERVICES RECEIVED AT THE TAKE CARE CLINIC**.

❑ NO — If *NO* please proceed to next question. In the event that the Terminated Person does not apply for unemployment benefits and receive a government issued determination letter evidencing the Terminated Person's qualification for unemployment benefits and submit such letter to Take Care Health Systems within 21 days of submitting this completed Initial Certification Form to Take Care Health Systems, the Terminated Person and all related parties **DO NOT QUALIFY FOR TCRP AND MUST PAY FOR ALL SERVICES RECEIVED AT THE TAKE CARE CLINIC**.

5. <u>PLEASE CONFIRM TAKE CARE CLINIC VISIT PRIOR TO JOB LOSS</u>

HAS ANY ONE OF THE FOLLOWING RECEIVED SERVICES AT A TAKE CARE CLINIC PRIOR TO THE TERMINATED PERSON'S DATE OF EMPLOYMENT TERMINATION? (PLEASE CHECK ALL APPLICABLE BOXES).

TERMINATED PERSON
- ❑ YES
- ❑ NO

TERMINATED PERSON'S SPOUSE/SAME-SEX DOMESTIC PARTNER
- ❑ YES
- ❑ NO

TERMINATED PERSON'S CHILD (18 months through 18 years of age)
- ❑ YES
- ❑ NO

THE CHILD OF A TERMINATED PERSON'S SPOUSE/ SAME-SEX DOMESTIC PARTNER (18 months through 18 years of age)
- ❑ YES
- ❑ NO

If *NO* to all please STOP: the Terminated Person and all related parties DO NOT qualify for TCRP.

If *YES* to any; please provide the following:

Name(s) of Patient(s):____

Date(s) of Birth: ____

Prior Health Coverage ID(s) (if applicable): ______________________________________

6. <u>PLEASE CONFIRM UNINSURED STATUS</u>

DOES ANY ONE OF THE FOLLOWING CURRENTLY HAVE ANY TYPE OF HEALTH INSURANCE OR HEALTH COVERAGE? (PLEASE CHECK ALL APPLICABLE BOXES).

TERMINATED PERSON

- ❑ YES — If *YES* please **STOP: the Terminated Person and all related parties DO NOT qualify for TCRP offer.**
- ❑ NO

TERMINATED PERSON'S SPOUSE/SAME-SEX DOMESTIC PARTNER

- ❑ YES — If *YES* **Terminated Person's spouse/same-sex domestic partner DOES NOT qualify for TCRP offer.**
- ❑ NO

TERMINATED PERSON'S CHILD(REN) (18 months through 18 years of age)

- ❑ YES — If *YES* **Terminated Person's child(ren) DO(ES) NOT qualify for TCRP offer.**
- ❑ NO — If *NO* please provide name(s), date(s) of birth and Social Security number(s) below for each child.

SPOUSE/SAME-SEX DOMESTIC PARTNER'S CHILD(REN) (18 months through 18 years of age)

- ❑ YES — If *YES* **the child(ren) of the spouse/same-sex domestic partner DO(ES) NOT qualify for TCRP offer.**
- ❑ NO — If *NO* please provide name(s), date(s) of birth and Social Security number(s) below for each child.

UNINSURED FAMILY MEMBERS

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY):	Social Security# (XXX-XX-XXXX):
				/ /	
Prior Health Coverage Provider Name:		ID Number:		Group Number:	

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY):	Social Security# (XXX-XX-XXXX):
				/ /	
Prior Health Coverage Provider Name:		ID Number:		Group Number:	

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY):	Social Security# (XXX-XX-XXXX):
				/ /	
Prior Health Coverage Provider Name:		ID Number:		Group Number:	

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY):	Social Security# (XXX-XX-XXXX):
				/ /	
Prior Health Coverage Provider Name:		ID Number:		Group Number:	

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY):	Social Security# (XXX-XX-XXXX):
				/ /	
Prior Health Coverage Provider Name:		ID Number:		Group Number:	

Last Name:	Suffix:	First:	Middle:	Date of Birth (MM/DD/YYYY):	Social Security# (XXX-XX-XXXX):
				/ /	
Prior Health Coverage Provider Name:		ID Number:		Group Number:	

ADDITIONAL INFORMATION

Take Care Clinic you are requesting to visit:

May we contact you in the future regarding news about Take Care Clinics? ❑ Yes ❑ No

Take Care Health Systems will send confirmation of qualification or disqualification for TCRP offer for each Family Member to the email address listed below. If you do not have email, please provide alternative contact information. By providing your contact information below you authorize Take Care Health Systems to contact you to provide such notification of qualification or disqualification for TCRP offer for each Family Member. <u>All Take Care Health Systems decisions about whether any particular individual qualifies for TCRP offer are final</u>.

Your Email Address: ______________________________

Your Mailing Address: ______________________________

____

Your Phone Number: ______________________________

I certify that all information provided in this Initial Certification Form is true, accurate and complete and understand that any false, fraudulent, fictitious or misleading information may result in disqualification from participating in the Take Care Recovery Plan offer.

I further certify that the Terminated Person identified in this Initial Certification Form is receiving, or is waiting for a determination from a government agency that s/he is eligible to receive, unemployment benefits as a result of a termination of employment occurring on or after March 31, 2009 and that, as a condition to participation in the Take Care Recovery Plan offer the Terminated Person must submit all supporting documentation, including verification of unemployment benefits, along with this Initial Certification Form or within twenty-one (21) days of submitting this Initial Certification Form to Take Care Health Systems. I understand that this Initial Certification Form is considered submitted to Take Care Health Systems on the date it is mailed or faxed to Take Care Health Systems or delivered to a Take Care Clinic. I understand that failure to provide all supporting documentation, including verification of unemployment benefits, will result in disqualification from participation in the Take Care Recovery Plan offer.

I further certify that all Family Members seeking free limited primary health care and diagnostic testing services pursuant to the Take Care Recovery Plan offer are not covered under any publicly funded or private health insurance plan or any other health coverage program, including COBRA coverage, Medicare and Medicaid. I further agree that if any Family Member does not qualify for the Take Care Recovery Plan offer at the time of the patient visit, he or she will be financially responsible for the cost of his/her visit and that Take Care Clinic shall bill the Family Member the Take Care Clinic regular charge for the health care and diagnostic testing services provided. I understand that if any Family Member receives services in a Take Care Clinic and is found to have health coverage or health insurance of any kind, Take Care Health Systems will submit a claim for reimbursement to the health coverage or health insurance provider for all services provided. I agree that such Family Member shall execute any and all required documents and take any actions necessary for Take Care Health Systems to receive reimbursement from the health coverage or health insurance provider.

I further certify that any same-sex domestic partner indicated above is in a domestic partnership with the Terminated Person which has been in existence for a period of at least six (6) months; that the Terminated Person and the same-sex domestic partner are not blood relatives and neither is legally married to any other individual.

I understand that the Take Care Recovery Plan offer is NOT insurance, NOT a medical discount plan and NOT a healthcare discount program and that the Take Care Recovery Plan offer has not been reviewed or endorsed by any regulatory authority.

Lastly, I certify that I have read, understand and agree to the TERMS AND CONDITIONS of the Take Care Recovery Plan offer.

SIGNATURE: ______________________________ **DATE:** ______________________________

PRINT NAME:______________________________