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**CATCH**

**Client Responsibility Agreement**

**What is CATCH?**

CATCH, a program of Community Health Partnership, works with local safety net clinics to provide low-income, uninsured individuals access to free or reduced cost specialty care and diagnostic services. All CATCH clients are screened by a safety net clinic to ensure they meet eligibility criteria for the program. In order to receive donated services through the program, all eligible individuals must sign a “Client Responsibility Agreement.” CATCH staff, in partnership with the safety net clinics, monitor compliance within the program.

# The care provided to you is being given without expectation of payment or compensation - unless there is a reduced co-pay associated with the service. Doctors, hospitals and many others are volunteering their services to help you get well and stay well. CATCH is not insurance or a government entitlement program. Our help may end at any time, for any reason. By signing this form, you agree to follow the Client Responsibilities listed below and authorize CATCH to verifythe information you have provided. You may be required to pay for any assistance you receive based on inaccurate information that you provide.

# As a CATCH Client, you agree to the following (failure to follow the responsibilities may result in you losing your CATCH assistance):

1. I will **keep each doctor’s appointment or notify their office at least 24 hours ahead of time** if I am unable to keep my appointment.Missed appointments may result in being ineligible for the program.
2. I authorize CATCH, the safety net clinic, clinicians, and service providers to share important information about my health. I will sign a Release of Information provided by the safety net clinic.
3. I will schedule appointments with only the doctors or clinics to which I have been referred, and I will notify the safety net clinic and the CATCH Coordinator when I am scheduled for other doctor appointments or testing.
4. I will be courteous, on time, and prepared for every appointment (e.g., take records and other reports, if requested).
5. I will notify the provider if I need an **adult translator or interpreter in advance** of my appointment.
6. I will immediately contact the safety net clinic if there are any changes in my income, address, or phone number, or if I become eligible for Medicaid, private insurance, or access other healthcare benefits.
7. I will promptly supply eligibility information that may be requested by the safety net clinic. I will apply for Medicaid or other assistance programs at my safety net clinic’s request.
8. I understand that not all services are available through the CATCH program and understand that CATCH will do their best to refer me to the best source of care.
9. I understand that **not all** of the health services I receive through this program are free. I will work with the safety net clinic and/or my physician to understand these costs and develop a payment plan as needed.
10. If I am not in compliance with any of these responsibilities, I understand that I may be removed from the program.

## By signing below, you confirm that you understand and agree to the above responsibilities.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Safety Net Clinic that Referred You to CATCH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_