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**CATCH Program and**

**Client Responsibilities Agreement**

**What is CATCH?**

CATCH, a program of Community Health Partnership, works with local safety net clinics to provide eligible 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 review and initial this agreement.

# The CATCH Client agrees to the following:

* I will schedule my own appointment with the specialist or diagnostic test appointment once I receive approval from the CATCH Coordinator. I will make every effort to be there, but if I am unable to attend, I will notify their office at least 24 hours ahead of time.
* I will schedule appointments with only the specialists or clinics to which I have been referred.
* After I schedule my appointment with the specialist or testing site, I will notify the safety net clinic of the appointment date and time.
* If I need an adult translator or interpreter, I will notify the specialist’s office in advance of my appointment.
* I will be on time and prepared for every appointment (e.g., take records and other reports, if requested).
* I authorize CATCH, the safety net clinic, and clinicians to share important information about my health. I will sign a Release of Information, as provided by the safety net clinic.
* I will notify the CATCH Coordinator if I am referred for any testing outside of the specialist’s office. If not coordinated, this could result in a bill.

* I understand that there may be some services in this program that are not free, for which I will be billed. I expect the office/testing site to tell me this ahead of time so that I can decide whether or not to proceed.
* I will immediately contact the safety net clinic if there are any changes in my income, address, phone number, or if I become eligible for Medicaid, private insurance, or access other healthcare benefits.
* 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, if appropriate.

Initials below indicate that safety net clinic staff and the patient have reviewed the agreement on this date:

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

Initials of safety net clinic staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials of CATCH client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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