CARAH MEDICAL ARTS

Administrative Office: 317 Church St, Phoenixville, PA 19460
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Solidarity and Family Support Fund Application

Thank you for your interest in joining Carah Medical Arts and filling out this application! Healthcare has a real value and real costs. One of the pillars of Carah Medical Arts is that a community of individuals and organizations supports it economically, out of a wish to make possible a different kind of healthcare for one's neighbor and one's community. Because of this commitment, Carah Medical Arts is able to have a Solidarity and Family Support Fund and through it support Patient Members for whom the reduced membership rate poses a financial hardship.

A portion of the membership fees is allocated to the Solidarity and Family Support Fund. In addition, the Solidarity and Family Support Fund receives donations from individuals and organizations wishing to support access to integrative primary care for individuals and families with less financial means. Individuals and families who are unable to afford the reduced membership rate may apply for financial support through the Solidarity and Family Support Fund. Based on a case-by-case needs assessment, financial support of up to 100% is available. It is our goal to enable everyone interested in the care available at our clinic to become a Patient Member, regardless of ability to pay. However, availability of financial support is limited by the funds available in the Solidarity and Family Support Fund at any given time and availability will be based on need and order of application.

We ask you to keep these thoughts in mind when filling out this application. If you ask for more support than you truly need it means that other community members with economic need will not have access to support. On the other hand, we want to encourage you to apply if you want to become a Patient Member and are not able to without this support. We are aware this may often especially apply to families because of the manifold costs associated with raising children. The one-time enrollment fee will be waived if your application is approved. If you need services for which itemized fees are charged and you cannot afford these, please let us know.

Once we receive your application it will be reviewed by our Solidarity and Family Support Fund Committee. The information you provide, the review of it and the approval decision on it will be treated entirely confidentially. For continued support through the Solidarity and Family Support Fund a new application is required every twelve months.

Please answer the following questions. For this application, "household" means the immediate family of spouses and/or parents and children residing at the same address.

1. What is your annual household income? $_____
2. What are your household assets (savings, real estate, stocks, other items of significant value etc. over $10,000 for individuals/over $20,000 for families)? $_____
3. How many people live in your household? _____
4. How many people in your household are applying as Patient Members with support through the Solidarity and Family Support Fund? _____ adults _____ children
5. How much can you contribute for these Patient Memberships per month? $_____

6. Please provide a short narrative explaining your need for support through the Solidarity and Family Support Fund.

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Your preferred primary physician at Carah Medical Arts may have a waiting list at this time. Please check online at carahmedicalarts.org under “Join Us”, “New Patient Members” or inquire via phone if your preferred physician is accepting new Patient Members.

How many people in your household prefer Dr. Knauf as their primary physician?_____

How many people in your household prefer Dr. Greer as their primary physician?_____

How many people in your household would like to have as their primary physician whoever of the two can see them first?_____

Please complete, date and sign this application form and mail it to Carah Medical Arts, 317 Church Street, Phoenixville, PA 19460. By signing you confirm that you have made your best effort to determine your financial need and that the information provided by you on this form is true to the best of your knowledge.

Unless you object in writing, we will notify you via email about the decision on your application. If you do not authorize us to communicate this decision with you via email, it will not have any effect on the review and approval process. If your Solidarity and Family Support Fund Application is approved, we will ask you to complete the paper work for becoming a Patient Member.

We will notify you via email when the renewal for your Solidarity and Family Support Fund Application is due (every twelve months). It is your responsibility to inform us if your email address changes. You acknowledge that if you do not renew your application within 30 days after we have sent you this notice, your membership fee will be changed to the reduced membership rate ($68 per month per adult; $40 per month per child up to age 26 if another household member contributes at the adult level). _____ *(initial here)*

Name: _____

Address: _____

_____

Email: _____

Phone: _____

_____ _____

Date (MM/DD/YYYY) Signature