Agreement between Sindecuse Health Center and WMU Student/Patient

1) Students must meet WMU “enrolled student eligibility” guidelines. The program ceases at the time of graduation or change in enrollment status.

2) Must meet Sindecuse Assisted Care defined financial guidelines and provide supporting evidence of financial need, e.g., FAFSA documents; documented exceptions by FAFSA; dependency status; current check stubs. Must not have any other source of insurance or Medicaid.

3) Sindecuse Assisted Care is not intended to cover copays required by an individual’s health insurance company.

4) Sindecuse Assisted Care is not intended to pay for care for students who choose not to use their health insurance for any reason.

5) Limit to $500 of written down care at Sindecuse Health Center per year. Students must be “certified” eligible with Sindecuse Assisted Care Representative annually.

6) Exceptions determined by Sindecuse Assisted Care Representative and documented thoroughly. Clinician encouraged referral to Sindecuse Assisted Care program for exceptions based on medical urgency of care.

7) Sindecuse Assisted Care will be “graded” according to income.

8) No show fees will be applied to the student account.

9) Student agrees to follow through with available community programs and applications (Medicaid, pharmaceutical patient assistance programs) as recommended. Upon failure to apply to community programs, Sindecuse Assisted Care may be revoked.

10) Sindecuse Assisted Care will not cover students for care at other facilities. If patient financial assistance is needed at other facilities, it is the student’s responsibility to request this directly through those facilities.

11) Covered services are based on health need and limited to Sindecuse Health Center clinic appointment.

I verify that the information provided in this application is complete and accurate and that without enrollment in the Sindecuse Assisted Care program, I would not be able to afford my recommended medical care. I understand that my eligibility for this program will terminate if the program becomes aware of any fraud on my part. I understand that Sindecuse Health Center reserves the right to modify or discontinue this program at any time. I understand that completing this application does not ensure that I will qualify for the Sindecuse Assisted Care program. If my financial and/or insurance situation should change, I agree to provide this information to Sindecuse Health Center, and this plan will end. I understand that bills incurred beyond the $500 limit will be billed to my student account.

Student

Date

Sindecuse Assisted Care Representative

Date

11/2013; revised 2/15