Official Use Only: Membership ID: **New/Renewal** **Start Date:** **Expiry:**

Payment Method: Cash/Check/Paypal **Amount:** **Appr Date:** **Approved by:**

Compassionate Care Network-NJ Member Application and Agreement

Full Name: _____ Date of Birth: _____

Address: _____

Telephone (H): _____ Cell Phone: _____CCNNJ ID:_____

Print Email Address: _____Date: _____

General Description of the CCNNJ Program. Compassionate Care Network-New Jersey, Inc. A Nonprofit Corporation, ("CCNNJ") operates a program (hereinafter referred to as the "CCNNJ Program") by which the CCNNJ network of health care providers agree to provide health care services to individuals who are eligible for membership (hereinafter referred to as "Members"). The CCNNJ Program is not an insurance program and it does not provide benefits for services provided by hospitals, emergency rooms, or other types of health care facilities. Rather, it is a program to assist Members obtain non-emergent professional health care services at a discounted rate from a network of health care providers that have agreed to participate in the CCNNJ Program (hereinafter referred to as "Participating Providers").

Eligibility. Individuals are only eligible for the CCNNJ Program if they do not have any health insurance of any kind. The CCNNJ Program is not available to any individual who is eligible for health care benefits under Medicare, Medicaid, or any other federal or state governmental program. CCNNJ reserves the right to modify its eligibility criteria.

Family Membership. Family membership is available to individuals who are married to each other and their children. The Member who has signed this Member Application and Agreement is responsible for providing CCNNJ and Participating Providers with accurate and timely information about which individuals are included in the Member's family membership. As noted above, no individuals, including any family members, are eligible they have health insurance of any kind.

Please check one box: Family Membership : /__/ Yes /__/ No

Membership Fee. Members are responsible for paying the Membership Fee in accordance with the following: The Individual Membership Fee is $60 for six months; the Family Membership Fee is $90 for six months. The Membership Fee is due upon signing this Member Application and Agreement and is automatically due upon the expiration of each 6 month period thereafter. CCNNJ may waive or reduce the Membership Fee at its sole and absolute discretion.

Office Visit Fee. In addition to the membership fee noted above, Members are responsible for paying a flat fee of $25 due at the time of service for any visit with respect to primary care services rendered by a CCNNJ Participating Provider and $35 with respect to any specialty care services rendered by a CCNNJ Participating Provider. The office visit fee only covers professional services performed in the Participating Provider's office during that visit. **The office visit fee will not cover lab, X-ray, vaccines, or any other products or services provided to the Member which, accordingly, are entirely the Member's responsibility.**

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Effective Date of Membership. Upon CCNNJ's receipt of the initial Membership Fee and this fully executed Member Application and Agreement, CCNNJ will promptly process the application and will make best efforts to activate the membership within 10 business days. Upon an individuals receipt of notice that this Application and Agreement has been accepted, the individual and, if applicable, eligible family members, shall be deemed an active Member and shall then be permitted to participate in the CCNNJ Program. CCNNJ may give notice of its acceptance of this Application and Agreement via telephone, email, or other written correspondence.

Denial of Application. CCNNJ reserves the right to deny this Application and Agreement in its absolute and sole discretion, in which event CCNNJ shall promptly return to the applicant 100% of the Membership Fee submitted in connection herewith.

Services Performed Elsewhere. Any procedures, laboratory specimen testing, consultations, surgeries, etc. performed outside of the Participating Provider's office will not be covered under the CCNNJ Program and all payments for such services are entirely the Member's responsibility.

No Claim Forms. Participating Providers will not issue forms for submission to any insurance company, HMO, or other type of health plan.

Termination of Participation. Member may terminate their participation in the CCNNJ Program at any time by notifying CCNNJ of their intent to do so in writing. CCNNJ may terminate this Member Application and Agreement upon 90 days prior written notice to the address above. If this Agreement is terminated pursuant to this Paragraph by either party, CCNNJ will refund, on a pro-rata basis, any unused portion of Membership Fee to the Member.

Waiver of Responsibility by CCNNJ. CCNNJ is not a health care provider and is not responsible for any health care decisions, health care treatment, health care guidance, or health care advice, under any circumstances. Participating Providers are solely and exclusively responsible for all aspects of clinical care and clinical decision-making they provide to Members. Accordingly, all Members agree that CCNNJ shall not be responsible for any acts or omissions of any Participating Providers. Members also acknowledge and accept the fact that CCNNJ had not made and makes no representation or endorsement of any Participating Provider regarding their professional competence or the quality of care they render to Members.

Entire Agreement. This CCNNJ Program Agreement constitutes the entire agreement between the Member and CCNNJ regarding the CCNNJ Program

Applicant's Statement and Signature:

I have read this CCNNJ Member Application and Agreement and I understand it. By signing below I affirm that: (i) I am eligible for the CCNNJ Program; (ii) I agree to and accept all provisions and terms set forth above; and (ii) the information I have provided above is accurate.

_____

Signature

_____

Date

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Print Name: _____DOB: _____

CCN NJ ID: _____

FAMILY DETAILS

Person's Name	Spouse/ Son/Daughter	DOB

_____

Signature

_____

Date

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