Clinical Alternative Relationship Plan Affiliation Agreement

Alternative Compensation and Delivery Unit

This information is collected under the authority of sections 20, 21(1)(a), 22(1), 22(2)(b) (if applicable), and 27(1)(g) of the *Health Information Act,* for the purpose of including the Affiliated Patient on the Clinic's Affiliated Patient List, and may be provided to the Minister of Health for purposes of the Program. If you have any questions about the collection of this information, please contact the Clinic.

◉ Affiliation ◯ De-Affiliation

Patient Affiliation Status

- The physicians of the Clinic participate in an Alberta Health program which requires them to maintain a list of their patients (called Affiliated Patients) for accountability and compensation-related purposes.
- Although one objective of the Program is to create loyalty and commitment on the part of the Affiliated Patients to treat the Clinic as their medical home, Affiliated Patients may seek medical treatment elsewhere.

In signing and providing the information below, I acknowledge the following:

- The clinic has explained to me the Blended Capitation Model and I wish to be added to the Clinic's list of Affiliated Patients;
- I will inform the clinic as soon as possible of any changes to my information;
- I may be removed from the Clinic's list of Affiliated Patients (i.e., become a De-affiliated Patient), in any of the circumstances listed below and, in which case, I understand I am expected to seek a different medical home for my ongoing primary health care needs:
    - I sign and submit to the Clinic and/or the Minister of Health the De-affiliation form (of which copies are available from the Clinic or the Minister of Health);
    - I notify the Minister of Health in writing that I wish to de-affiliate from the Clinic;
    - I am admitted into a long-term care facility;
    - I complete a Patient Affiliation Form with another clinic;
    - I relocate to a location outside the municipality and surrounding area served by Clinic; or
    - I am otherwise notified by the Clinic or the Minister of Health that I have been de-affiliated in accordance with the Minister's Program parameters.

Patient's Name | Patient's Personal Health Number | Date of Birth yyyy-mm-dd

Gender ◯ Female ◯ Male | Patient's Home Phone Number (or Guardian's phone number if applicable) | Work Phone Number

Street Address | City or Town | Province (AB) | Postal Code

Date yyyy-mm-dd | Signature

If Applicable, Name of Guardian or individual with Power of Attorney acting for patient | Relationship to Patient

Mailing Address | City or Town | Province (AB) | Postal Code

Date yyyy-mm-dd | Signature

Signature of Participating Physician

As a Participating Physician of the CROWFOOT VILLAGE FAMILY PRACTICE Clinic, I acknowledge _____

Clinic Name | Name of Affiliated Patient

will be added to the Clinic's list of Affiliated Patients.

Participating Physician's Name | Date yyyy-mm-dd | Signature