Tribal Health

CONFEDERATED SALISH AND KOOTENAI TRIBES

P.O. Box 880
35401 Mission Dr.
St. Ignatius, MT 59865
Ph. (406) 745-3525
Fax (406) 745-4719

Application for Service

PATIENT DEMOGRAPHICS:

Patient Legal Name ______________________________ Aliases: ____________________
(Last, First MI) *(Other names you may go by)*

Social Security #: ________________ Birthdate: __________ Age_______

Contact Information:

MAILING Address: ____
CITY STATE ZIP

PHYSICAL Address: ____
CITY STATE ZIP

Phone#: (____) ____________ (_____)____________ Ext: ________ (____) ______________
Primary Phone Work Phone Message Phone

Date moved to this address____________________

Marital Status: (circle one) Single / Married / Divorced / Separated / Widow/Widower

Do you want your medical information shared with anyone? Name: ____________________ DOB:____________

Emergency Contact: Name ____________________ Phone Number: __________________________
Last, First

Tribal Affiliation:

- ☐ CSKT Enrolled Member Enrollment #____________
  - o CSKT Descendant
- ☐ Other Federally Recognized Tribe ____________________ Enrollment #: ________________
  - o Descendant

Other, Please Specify: ____________________

Are you attending college? Yes / No Where? ____________________ FT ____ PT____

Are you employed? Yes / No Employer Name: ______________________Phone: ____________

Do you have private insurance? Or are you covered by your spouse and/or parent's insurance? () Yes () No

HEALTH INSURANCE INFORMATION: (Please provide copies of front and back of your card)

Insurance Company __________________________

Insured Name __________________ ID Number ______________________

Family Members included ____

Do you have Medicare? () Yes () No Part A___ Part B ___ Part D___ Number ____________

Do you have HMK Plus – Medicaid? () Yes () No HMK-CHIP? () Yes () No

Are you a Veteran? () Yes () No Are you covered by Veteran Medical Benefits () Yes () No
If yes, please provide your Veteran Health Identification Card.

Primary Care Provider and/or Clinic?______________________________

List all members of your household under 18 years of age: (Name and Date of Birth, PCP, and/or Clinic)

______________________ __________________________ ______________________
______________________ __________________________ ______________________
______________________ __________________________ ______________________

Internet Access: () Yes () No Where: (circle one) Home Work School Mobile

Email: ____________________________ Permission to send Tribal Health updates: Yes No

Are you interested in text message appointment reminders? () Yes () No Text # (____) ______ ________

RECIPIENT NAME: ____ **DATE OF BIRTH:** ________________

RECIPIENT PRIVACY RIGHTS (Public Law 93-579) I understand that the information given by me and/or collected is necessary for Tribal Health to provide for my well-being. Furthermore, I have been informed that my records shall not be disclosed to any other agency or person without my signed consent.

ASSIGNMENT OF BENEFITS (AOB) I understand Tribal Health (TH) has a right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. This AOB authorization is in effect until revoked by patient in writing. Further, I understand that Tribal Health may bring a claim or cause of action against a third party for recovery of such medical expenses.
Therefore, I agree as follows:
1)To assign to Tribal Health any claim of cause of action against the third party to the extent of the medical expenses paid, or any portion thereof
2) To furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given and concerning any action instituted by or against a third party
3) To notify Tribal Health of a settlement with or an offer of settlement, for myself or my dependents.
4) The AOB authorization is in effect until revoked by Recipient.

I hereby authorize Tribal Health to furnish information to insurance carriers and other third-party payers concerning my illness and treatment, and hereby assign all payments for medical services rendered to myself or my dependents.

CONSENT TO SERVICES
Recipient hereby consents to any services provided in connection with Recipient's treatment by Tribal Health (TH) health service providers and by independent health service providers affiliated with TH. These services may include, but are not limited to, inpatient, outpatient, and/or emergency services; diagnostic procedures; transportation; nursing care; and other healthcare services provided to Recipient upon the instructions of Recipient's providers. "Recipient acknowledges that no guarantees have been made regarding the outcome of these services. If the Recipient is unable to sign, consent for treatment: (1) is hereby given by representative(s) authorized to make decisions and sign this agreement on Recipient's behalf, or (2) in cases of emergency, shall be implied. The term "TH" includes the health care service providers owned or controlled by Tribal Health.

RELEASE OF INFORMATION I authorize Tribal Health to collect information on behalf of myself and my dependents. I understand that information received by Tribal Health will be kept confidential and used for professional purposes only in terms of facilitating services for me and my dependents. ***I have read and acknowledged ____yes ______ initial.***

ACKNOWLEDGMENT I acknowledge that Tribal Health may seek medical and/or other information necessary from any other entity that may be needed for continuation of care and/or eligibility for services. ***I have read and acknowledged ____yes _____initial.***

FRAUD STATEMENT Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty for each violation. ***I have read and acknowledge ____yes ____ initial.***

PAYER OF LAST RESORT I acknowledge that Tribal Health is the Payor of last resort, and therefore I must apply for and accept all medical benefits and/or Alternate resource coverage when available. ***I have read and acknowledged ____yes ______ initial.***

____ ____________________________

Signature of Applicant Printed Name

____ ____________________________

Signature of Legal Representative, if other than Applicant Date

**********************************Office Use Only**********************************

Date Received: ____________________ By: ______________________ HRN:_____________

Referred to Health Care Resource Advocate: ________________ MRN:_____________

Residency Confirmed: Off Reservation: ☐ On Reservation: ☐ Direct Care: ☐ THPC Eligible: ☐