YEARLY UPDATE APPLICATION

St Ignatius Tribal Health Clinic
PO Box 880
St. Ignatius, MT 59865
(406) 745-3525 phone
(406) 226-2774 fax

Polson Health Center
#5 Fourth Avenue East
Polson, MT 59860
(406) 883-5541 phone
(406) 226-2661 fax

Ronan Health Center
430 Mary McLeod Lane
Ronan, MT 59864
(406) 275-2799 phone
(406) 226-2692 fax

Apps can be turned in at the following locations, fax or email:

Email: registration@cskthealth.org

The following items are needed for this application:

_____ (1) Item for proof of residency (electric bill, rent/lease receipt, valid MT Driver's license, Tribal ID, voter registration card, and/or residential phone bill dated within the last 30 days). *required to be eligible for

_____ Medicaid/HMK Card policy number, Medicare card or letter of Denial (copy both sides of card).

_____ Private Insurance Card/Policy (copy both sides of the card)

Verify we also have the following documents on file:

_____ Proof of Tribal Enrollment or Descendancy (Tribal ID or official letter from tribe)

_____ Birth Certificate **

_____ Social Security Card **

you may be asked to submit these items if they are not in your current file!

**does not affect eligibility determination

Pregnant women also need to submit:

_____ Statement from your OB-GYN with Due Date

College Students also need to submit the following:

_____ Student status verification (official letter/official transcripts from the institute verifying full-time student status of 12 or more credits and duration of attendance)

_____ Contract Health Service eligibility letter from home reservation (if applicable)

If all required documents are NOT submitted with your application your eligibility status will be "Direct Care Only". An Eligibility Determination for "Tribal Health Paid Care" cannot be made until your application is complete. This means there will be no medical services paid by THPC for medical treatment received outside of our facility.

Annual Eligibility Update Required: In accordance with IHS Purchased/Referred Care (PRC) requirements under **42 CFR § 136.23**, eligibility for Tribal Health Paid Care (THPC) must be verified to ensure residency, alternate resources/insurance, and other eligibility information remain current. **Patients requesting THPC/paid care services are required to complete an eligibility update annually and report changes as they occur.**

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

09/12/2024

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

Date Received: _____ By: _____ HRN: _____

Referred to Health Care Resource Advocate: _____ MRN: _____

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