MILLE LACS BAND OF OJIBWE INDIANS

HEALTH AND HUMAN SERVICES REGISTRATION

ALL INFORMATION REQUESTED IS REQUIRED

2018

Health and Human Services Registration

- Please update information with the clinic if there are any changes to address, phone number, insurance coverage, etc.
- Any patient who DOES NOT have current health coverage will be referred to Circle of Health to be assisted to apply for coverage.
- All Tribal patients must have complete eligibility documentation on file to qualify for Purchased and Referred Care.
- If you have health records from another facility that are critical to the care you receive here, you must sign an authorization to release medical records to our facility.

FOR CIRCLE OF HEALTH ENROLLMENT (MILLE LACS BAND TRIBAL MEMBERS ONLY)

- You must complete and submit a new enrollment form annually, or each time you elect new health insurance coverage, or experience a change in family size.
- COH is a Mille Lacs Band of Ojibwe Tribal Member Program; your insurance premiums will be paid or reimbursed once all documentation is received or on file.
- COH Policyholder Notice: It is your responsibility to report any changes regarding your insurance coverage; this includes changes in employment as it relates to new employer eligibility or COBRA. Failure to report these events and changes to Circle of Health may result in a HOLD status on your benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for tribal benefits will be ineligible for Circle of Health benefits &/or Purchased and Referred Care.

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Name _____ **Suffix** _____ **SS#** _____
Last Name **First Name** **Middle Initial**

DOB _____ **Sex** ☐ M ☐ F **Birth Place** _____

Marital Status _____ **Race** _____ **Primary Language** _____

Tribe _____ **Enrollment #** _____

Address _____ **Homeless?** ☐
Street **City** **State** **Zip**

Phone _____ **County of Residence** _____

Phone _____ **Reminder Method** ☐ Phone ☐ Email ☐ Mail ☐Text

Email _____ **Internet Access** ☐Home ☐School ☐Cell Phone ☐Work

Mother _____ **Birth Place** _____

Father _____ **Birth Place** _____

Legal Guardian/ Emergency _____ **Relation** _____

Address _____ **Phone** _____

Veteran ☐ Yes ☐ No **Dates of Service** _____ - _____ **Service Branch** _____

VA Card ☐ Yes ☐ No **VA Disability** ☐ Yes ☐ No **Service Connected** ☐ Yes ☐ No

Employer _____ **Employed** ☐ Full Time ☐ Part Time

RCV'D		RCV'D	
	TRIBAL ID OR CERTIFICATE OF ENROLLMENTS FOR ALL		NAME CHANGE DOCUMENTATION
	COPIES OF HEALTH INSURANCE CARDS		MARRIAGE CERTIFICATE
	BIRTH CERTIFICATES FOR MINORS/ DESCENDENTS		PROOF OF STUDENT STATUS FOR DESCENDANTS OVER 18 (COH ONLY)
	SS #'S FOR ALL		GUARDIANSHIP

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Insurance Coverage: (Please check all that apply for your household)

☐ **I DO NOT HAVE ACTIVE HEALTH INSURANCE** *(CONTINUE TO PG 3)*

☐ **Medicaid (MA)** ☐ **MN Care** **Medicare:** ☐ Part A ☐ Part B ☐ Part D **Employer:** ☐ Medical ☐ Dental

POLICYHOLDER Carrier(s)

Policy Number Group

List all individuals covered by your primary insurance policy

Name	Relationship to Policyholder (self, spouse, child/other)	Date of Birth	Social Security Number
	Policyholder		

Copy of Insurance Coverage <u>MUST BE</u> Attached

Tribal Member and Descendant Verification Documents Needed:

1. Birth certificates for all 1st generation descendants 2. Tribal ID Card or Certificate of Enrollment

List all individuals who are tribal members or descendants

Name	MLB Descendant or MLB Enrolled Member	Enrollment #	Name of Enrolled Parent
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		

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Assignment of Benefits (AOB*)

I understand the Tribal Health and Human Services (HHS), Circle of Health (COH), and Purchased/Referred Care (PRC) 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. Further, I understand that HHS may bring a claim or cause of action against the third party for recovery of each medical expense.
Therefore, I agree as follows:

1. To assign to the HHS/PRC/COH any claim of cause of action against the third person 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 or to be instituted by or against a third party.
3. To notify the HHS/PRC/COH of a settlement with, or an offer of settlement from a third person and
4. To cooperate in the prosecution of all claims and actions by HHS/PRC/COH against such third person.

I authorize HHS/ PRC/ COH to furnish information to insurance carriers, and other third party payers' concerning my medical care and treatment to process claims in accordance with HIPAA health information standards. I assign all payments to be paid directly to HHS/PRC/COH for medical services rendered to me or my dependents. Confidentiality of records including information related to diagnosis of mental health, substance abuse, HIV/AIDS, and sexually transmitted disease are maintained per regulatory standards. This AOB authorization is in effect for one year, or if there is a change in health insurance coverage.

RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICE

I acknowledge that I have received/reviewed or have been offered the opportunity to receive a copy of the Notice of Privacy Practices for this facility. I certify that the above information provided to be accurate and true to the best of my knowledge and authorize HHS/PRC/COH to verify the accuracy of this application.

Print Name _____

Signature _____Date: _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH

P.O. BOX OR STREET ADDRESS	CITY	STATE, ZIP	COUNTY	TELEPHONE NUMBER

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING: I authorize and consent Mille Lacs Band of Ojibwe HHS/ Circle of Health/ Purchase Referred Care to use my electronic and paper health records to track, communicate and share the following information. I understand that certain programs and benefits may be restricted to enrolled tribal members and eligible first generation tribal descendants. I understand that I must show proof of birth, guardianship or legal custody, if requested. I understand that any missing information will delay the eligibility process. I certify that the above information provided is accurate and true to the best of my knowledge and authorize HHS/PRC/COH to verify the accuracy of this application. All the information provided on this enrollment form is CONFIDENTAL and protected by the rules and regulations of the Data Privacy Act of 1974. The information will be shared within HHS/PRC/COH to determine eligibility.

I understand that this general information may include but is not limited to the disclosure of, receipt of or exchange with the following:

- Insurance and Billing information
- Social service information
- Court/Legal information
- Verbal exchange
- Eligibility for State and Federal Programs
- Provider Claims
- Health Services information
- Housing information
- Tribal Enrollment information
- Worker's Compensation or General Liability Claims
- Insurance Premium Payments
- Employer Income Verification

REVOCATION AND CONSENT:

I understand that I may revoke this consent to release information at any time by written notice, except when legal action prevents revocation (probation, court confinement, court ordered). However, any release made in good faith prior to receipt of revocation, shall be deemed valid. I also understand that information disclosed by this consent cannot be released to anyone else unless I give written permission.

ATTENTION: THIS IS A LEGAL DOCUMENT. PLEASE READ CAREFULLY. BY SIGNING, YOU AGREE THAT YOU UNDERSTAND AND ACCEPT THE TERMS ON THIS FORM. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNING UNLESS WRITTEN REQUEST FOR IMMEDIATE REVOCATION.

- **IF THE PATIENT IS 18 YEARS OF AGE OR OLDER, THE PATIENT MUST SIGN AND DATE THE FORM.**
- **IF THE PATIENT IS 18 YEARS OF AGE OR OLDER AND IS INCAPABLE OF SIGNING, A LEGALLY AUTHORIZED REPRESENTATIVE MAY SIGN AND DATE THE FORM.**

PLEASE INDICATE YOUR LEGAL AUTHORITY AND INCLUDE DOCUMENTATION OF YOUR REPRESENTATION RELATIONSHIP.

Signature	Signature of Parent/Guardian (if under 18)
Date	Relationship to member

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