Data Entry ________
Verified __________
HRN ______________

# COWLITZ INDIAN TRIBE

☐ New Patient
☐ Update
☐ CHS/PRC

Health Services Registration Form

Legal Name: ______________________________ DOB: ______________
Preferred Name (optional): ______________________ Maiden/Other: ______________
Gender Assigned at Birth: ☐F ☐M ☐Intersex ☐Not listed: ______________________
Gender Identity (optional): ☐ Two Spirit ☐Woman ☐Man ☐Transgender ☐Trans Man
☐Trans Woman ☐Nonbinary ☐Agender ☐Genderfluid ☐Not listed: ______________
Preferred Pronouns (optional): ☐She/Her ☐He/Him ☐They/Them ☐Not listed: ____________
Social Security #: ____________ Marital Status: ☐S ☐M ☐D ☐W ☐Other: __________
Physical Address: ___________________________ Or: ☐Unsheltered ☐No Fixed Address
City: __________________ State: ______ Zip: __________ County: ___________
Mailing Address (if different): ____________________________________________
City: __________________ State: ______ Zip: __________ County: ___________
Primary Phone: __________________ Permission to leave general message: ☐Yes ☐No
Secondary Phone: ________________ Email: ___________________________
Emergency Contact: ______________________ Relationship: ______________
Address: ______________________________ Phone: ___________________
Work Status: ☐Full Time ☐Part Time ☐Retired ☐Disabled ☐Unemployed ☐Student
Student Status: ☐K-12 ☐College ☐Full Time ☐Part Time ☐School: ______________
Employer Name: __________________________ Phone: ___________________
Address: ____________________ City: ____________ State: ______ Zip: ________

## PRIMARY INSURANCE INFORMATION

(☐) *I do not have primary insurance* ________ *(initials)*

Medical Insurance: __________________________ Phone: __________________
Address: ________________________________ Effective Date: ____________
Policy Holder: ☐Self ☐Spouse ☐Parent ☐Other: __________ ☐Purchased Through Health Plan Finder
Policy Holder Name (if other than self): ______________________________________
Policy Holder DOB: ____________ Social Security No. (if other than self): ______________
Employer Providing Coverage (if applicable): ______________________ Phone: __________
ID #: ______________ Group #: _________________ Rx Name/ID#: ________________
Dental Insurance Name/ID#: ____________________________________________
Optical Insurance Name/ID#: ___________________________________________

## SECONDARY INSURANCE

(☐) *I do not have secondary insurance* _______ *(initials)*

Medical Insurance: __________________________ Phone: __________________
Address: ________________________________ Effective Date: ____________
Policy Holder: ☐Self ☐Spouse ☐Parent ☐Other: ______________________________
Policy Holder Name (if other than self): ______________________________________
Policy Holder DOB: ____________ Social Security # (if other than self): ________________
Employer Providing Coverage (if applicable): ______________________ Phone: __________
ID #: ______________ Group #: _________________ Rx Name/ID#: ________________
Dental Insurance Name/ID#: ____________________________________________
Optical Insurance Name/ID#: ___________________________________________

## TRIBAL AFFILIATION INFORMATION

Name of Tribe or Corporation: ______________________________

☐ Enrollment #: ______________________ ☐Non-Enrolled Descendent (supporting documents required)

Please provide name(s), date(s) of birth, and relationship for other Native members of your household:

______________________________

Race/Ethnicity: ______________________ Language: ________________ Interpreter Needed: ☐Yes ☐No

## LEGAL DOCUMENTS

Do you have legal documents that pertain to your health and wellness? ☐Yes ☐No

If yes, please list and provide copies (i.e., advanced directives, power of attorney, living will, guardianship, custody, etc.): ______________________________

## VETERAN STATUS

Are you a US Veteran? ☐Yes (Thank you for your service!) ☐No (skip to next section)

If Yes, Entry Date: ______________________ Do you have a service-connected disability? ☐Yes ☐No

## AUTHORIZATIONS

________ Initial here confirming you have received a copy of the Notice of Privacy Practice.

________ Initial here confirming you have received a copy of the Patient's Rights and Responsibilities.

________ Initial here to consent to receive information related to treatment, payment or health care operations, including receiving autodialed and prerecorded message calls and/or text messages at all telephone or text numbers I have provided or, if not current, to any number I am reasonably found to be associated with.

________ Initial here confirming you have been notified that most laboratory services will be performed and billed by a facility outside of the Cowlitz Indian Tribe (CIT) and you understand that you and/or your insurance provider are responsible for costs associated with these services.

________ Initial here confirming the following **(COWLITZ TRIBAL MEMBERS ONLY):** I understand 42 CFR 136.23 mandates that I provide true and accurate information used to make an eligibility determination prior to approval of federal funds being expended on my behalf. I understand that information provided on my application may be verified to ensure compliance with federal law and the Cowlitz Tribe's Self Governance Agreement. I understand that providing false or incomplete information could result in non-compliance with federal regulations, and to the best of my knowledge, I attest to the accuracy of the information submitted on this application. I understand 42 CFR 136.61 mandates that CHS/PRC is a payor of last resort and that I am required to apply for and utilize all alternate resources available to me. If I am un-insured or underinsured, I will be required to apply for state medical/dental coverage and that I may only decline if there is a cost associated with accepting coverage. I am aware that as a CIT Member I must maintain residency in the Tribe's designated service delivery area to access federal funds. If I relocate, I must notify the CHS/PRC program of my new residency. If I relocate to attend college and maintain status as a full-time student, I may remain eligible for CHS/PRC while in attendance. I am aware that demographic (phone/address) information may be shared with the Enrollment Department if applicable.

**ALL CLIENTS/PATIENTS:** My signature indicates, to the best of my knowledge, that all information provided is true and accurate. My signature authorizes the release of medical information necessary for diagnosis, treatment, and billing. I hereby authorize billing and payment of services, assign benefits otherwise payable to me to CIT, and request that payment be made to CIT directly. I agree to remit to CIT any payments sent directly to me for services provided by CIT.

Print Name: ______________________________ Relationship to Patient: ______________

Signature: ______________________________ Date: ______________________