

Data Entry _____
Verified _____
HRN _____



COWLITZ INDIAN TRIBE

☐ New Patient
☐ Update
☐ CHS/PRC

Health Services Registration Form

Legal Name: _____ D O B : _____
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: _____

FEDERAL/STATE COVERAGE

Medicare Part A ☐ Part B ☐ ID#: _____
Medicare Advantage Plan Name (Part C): _____ ID# _____
Dental Insurance Name/ID#: _____ Optical Insurance Name/ID#: _____
Hearing Insurance Name/ID#: _____ Prescription (Part D) ID #: _____
Medicaid Plan Name/ID#: _____
Medicaid Managed Care Plan Name/ID# _____

PRIMARY INSURANCE (☐) I do not have primary insurance ____ (initials)

Medical Insurance: _____ Effective Date: _____
Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ ☐ Purchased Through Health Plan Finder
Policy Holder Name (if other than self): _____ Policy Holder DOB: _____
ID #: _____ Group #: _____ Rx Name/ID#: _____
Dental Insurance Name/ID#: _____ Optical Insurance Name/ID#: _____

SECONDARY INSURANCE INFORMATION (☐) I do not have secondary insurance ____ (initials)

Medical Insurance: _____ Effective Date: _____
Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____
Policy Holder Name (if other than self): _____ Policy Holder DOB: _____
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: _____