HRN: _____

MILLE LACS BAND OF OJIBWE

Name:_____

HEALTH SERVICES ELIGIBILITY AND REGISTRATION FORM

ALL INFORMATION IS REQUIRED

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

DOB: _____ **Sex:** ☐ M ☐ F **Marital Status:** ☐Single ☐Married ☐Divorced ☐Never Married ☐ Separated ☐ Unknown ☐Widow/Widower

Address: _____
Street City State Zip County

Home Phone: _____ **Preferred Reminder Method:**
Work Phone: _____ ☐ Mail ☐ Text ☐ Email ☐ Phone
Email Address: _____ **Internet Access Locations:**
☐ Home ☐ Work ☐ School ☐ Clinic

Primary Language: _____ **Race:** ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic/Latino ☐ White ☐ Declined

Tribe: _____ **Enrollment #:** _____ **Quantum:** _____

Birth City: _____ **State:** _____

Father: _____ **Birth City:** _____ **State:** _____ **Phone:** _____

Mother: _____ **Birth City:** _____ **State:** _____ **Phone:** _____

Next of Kin: _____ **Relation:** _____ **Phone:** _____

Address: _____
Street City State Zip

Veteran: ☐ Yes ☐ No **Service Branch:** _____ **VA Card:** ☐ Yes ☐ No **VA Disability:** ☐ Yes ☐ No **Service Connected:** ☐ Yes ☐ No

Service Date of Entry: **Service End Date:**

Homeless: ☐ Yes ☐ No **Homeless Type:** ☐ Doubling up ☐ Shelter ☐ Street ☐ Transportation ☐ Other

---

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

Emergency Contact

Name: _____ **Relation:** _____

Address: _____
Street City State Zip

Phone: _____ **Work Phone:** _____

NEED	REC'D	DOCUMENTS (OFFICE USE ONLY)	NEED	REC'D	DOCUMENT (OFFICE USE ONLY)
		Social Security Card			Birth Certificate (Original or certified copy)
		Tribal Enrollment/Decadency Marriage Certificate (Spouses) Official Letter or Photo ID			Two (2) items for Proof of Residency (rent or utility receipt, MN Driver's License, school attendance, voter's registration card, etc…)
		Medicaid, Medicare, or Private Insurance			MLB Employee ID

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

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HEALTH SERVICES ELIGIBILITY AND REGISTRATION FORM

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PATIENT'S CURRENT INSURANCE COVERAGE

☐ No Insurance (proceed to next page) ☐ I Do Have Insurance (complete form & sign OR attach card)

☐ Employer Insurance Employer Name: _____

___ Medical

___ Dental _____

Address City State/ZIP

___ Medicare ___ Part A ___ Part B ___ Part D ___ Medicaid (MA) ___ MNCare Card copy on file? Y / N

Policyholder Notice: It is your responsibility to report any changes regarding your insurance coverage, this includes employment as it relates to new employer eligibility or COBRA.

_____

Name (Last, First MI) Policy Name and Policy #

_____

Street Address (if different) City State/ZIP

_____

Telephone Number Social Security # (if patient is not policy holder) DOB (if patient is not policy holder)

List all individuals covered by your primary insurance policy

Name	Relationship to Policyholder (self, spouse, child/other)	Date of Birth	Enrollment #	Mille Lacs Tribal Member Yes or No
	SELF			

All the information provided on this enrollment form is CONFIDENTIAL and upheld by the rules and regulations of the Data Privacy Act of 1974. The information will be shared with Circle of Health and Purchased/Referred Care to determine eligibility within these programs. For a complete copy of the Privacy Act of 1974 Public Law93-579 can be made available upon request.

_____ _____

Signature Date

Patients may provide a thumb print for authorization in place of signature.

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

HRN: _____

MILLE LACS BAND OF OJIBWE

Name:_____

HEALTH SERVICES ELIGIBILITY AND REGISTRATION FORM

ALL INFORMATION IS REQUIRED*

RELEASE OF CONFIDENTIAL INFORMATION

PLEASE PRINT PATIENT INFORMATION *

_____

FIRST NAME **MI** **LAST NAME** **DATE OF BIRTH**

_____

P.O. BOX/ STREET ADDRESS **CITY** **STATE** **ZIP** **TELEPHONE NUMBER**

ONLY COMPLETE THIS BOX FOR LIMITATIONS:

I hereby authorize the Mille Lacs Band of Ojibwe Health and Human Services to:

☐ ***Disclose to*** ☐ ***Obtain from***

***All providers, employers, Mille Lacs Health &Human Services Departments, Mille Lacs TANF program & insurance companies* the following information:**

- ☐ ***Provider claims***
- ☐ ***Worker's compensation claims***
- ☐ ***General liability claims***
- ☐ ***Billings***
- ☐ ***Insurance premium payments***
- ☐ ***Eligibility options to state programs***
- ☐ ***All of the above***

For the time period beginning _____through_____

The purpose for this disclosure is ***for claims, premiums, reimbursements, & communication between above listed departments.***

REVOCATION AND CONSENT:

Upon fulfillment of the above stated purpose(s) this consent will automatically expire without express revocation, unless otherwise specified as follows: _____.

Valid for a maximum of one (1) year

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.

_____ _____

Signature/ Thumb Print (Parent/Guardian if under 18) **Date**

Patients may provide a thumb print for authorization in place of signature.

FOR OFFICE USE ONLY

_____ _____

Witness for Thumb Print **Date**

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

HRN: _____

MILLE LACS BAND OF OJIBWE

Name:_____

HEALTH SERVICES ELIGIBILITY AND REGISTRATION FORM

*****ALL INFORMATION IS REQUIRED*****

ASSIGNMENT OF BENEFITS

I understand that the information given by me and/or collected is necessary for the Tribal Health Services to provide for my wellbeing. 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 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/COH/PRC 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/COH/PRC 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 the HHS against such third person.

I hereby authorize HHS, COH, PRC, to furnish medical information including information related to diagnosis of mental health, substance abuse, HIV/AIDS, sexually transmitted disease, payment of medical bills and other information to the Office of Solicitor General, 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. (This AOB authorization is in effect for **one year** or until if other insurance coverage is acquired.)

I certify that the above information provided to be accurate and true to the best of my knowledge and authorize HHS to verify the accuracy of this application.

_____

Print Patient's Name

_____ _____

Signature/ Thumb Print (Parent/Guardian if under 18) **Date**

Patients may provide a thumb print for authorization in place of signature.

FOR OFFICE USE ONLY

_____ _____

Witness for Thumb Print **Date**

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

HRN: _____

MILLE LACS BAND OF OJIBWE

Name:_____

HEALTH SERVICES ELIGIBILITY AND REGISTRATION FORM

*****ALL INFORMATION IS REQUIRED*****

PATIENT CODE OF CONDUCT

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Ne-Ia-Shing Clinic asks visitors, patients and accompanying family members to refrain from behaviors that are unruly or pose a threat to the rights or safety of other patients and staff. **The following behaviors will not be tolerated:**

1. Possession of firearms or any weapon
2. Physical abuse and arson
3. Throwing objects
4. Climbing on furniture
5. Making verbal threats to harm another person or destroy property
6. Intentionally damaging property
7. Making unfriendly gestures
8. Attempting to intimidate or harass other individuals
9. Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication/social media
10. Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality
11. Adults are expected to supervise their children.

Health & Human Services employees are Mandated Reporters. What is a Mandated Reporter?

Persons mandated to report suspected abuse or neglect include any physician, nurse, dentist, optometrist, or any other medical or mental health professional; other law officials, and other government employees.

Failure to comply with the Patient Code of Conduct, may lead to discontinuing scheduled (non-emergent) care for individuals and are subject to removal from the facility and/or discharge from the practice. If you are subjected to/ or witness inappropriate behavior, please report to any staff member.

I have read and understand the Ne-Ia-Shing Clinic Code of Conduct. I agree to follow the policies listed in the Code of Conduct and all federal, state, and local laws, rules and regulations for the duration of my association with Ne-Ia-Shing Clinic. I have read and understand the roles of a Mandated Reporter.

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.

Patient Name: _____

Signature: _____ Date: _____

Patients may provide a thumb print for authorization in place of signature.

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

HRN: _____

MILLE LACS BAND OF OJIBWE

Name:_____

HEALTH SERVICES ELIGIBILITY AND REGISTRATION FORM

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