

# CONFEDERATED SALISH AND KOOTENAI TRIBES TRIBAL HEALTH AND HUMAN SERVICES

P.O. Box 880  
St. Ignatius MT 59865  
Phone: 406-745-3525

1st Selection of PCP \_\_\_\_\_  
Request to Change \_\_\_\_\_  
Fax: 406-745-4719

## PRIMARY CARE PROVIDER (PCP) DESIGNATION FORM

Name of Person \_\_\_\_\_  
Selecting a PCP: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last
First
MI

Mailing Address: \_\_\_\_\_  
Box Number, Etc...
Town / City
State
Zip Code

Physical Address: \_\_\_\_\_  
Number, Street or Road, Housing Project, Etc...
Town/ City
State
Zip Code

Telephone: \_\_\_\_\_  
Home
Work
Message

Choice of Primary Care Provider: \_\_\_\_\_  
Please be Specific (Example: Dr. Smith, or Name Smith PAC, Etc...) Not Just Facility Name

If you are Female: Do you see an OB-GYN? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name of physician and facility where seen: \_\_\_\_\_

Others living in the household who are eligible for CHS:

Name	Birth Date	Social Security #	Primary Care Provider Selection	Health Record #

If any person above is seeing a pediatrician, OB-GYN, or other specialist, please state: 1) who and the specialist's name for each; 2) name of the association / facility where the physician is located:

\_\_\_\_\_

This is my \_\_\_\_\_ selection / change. I acknowledge that I can only change my PCP no more than 2 times within a year's time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Individual Completing This Form)

**PLEASE COMPLETE AND RETURN YOUR FORM AS SOON AS POSSIBLE**

Confederated Salish and Kootenai Tribes  
DEPARTMENT OF TRIBAL HEALTH AND HUMAN SERVICES  
(Beneficiary Services Program)

**CONSENT FOR RELEASE OF INFORMATION**

I/ We, the undersigned am/are seeking services from the Tribal Health and Human Services Department which includes, but is not limited to the following programs: Contract Health Services, Direct Services, Alternate Resources, Patient Registration, Community Health Nurses, Dental Program, Pharmacy, Third Party, Mental Health, Tribal Nutritionist, Diabetic Program, and Medical Records.

I/ We, authorize the above named programs to share, exchange ,or give and receive information about my application and contents therein, in an effort to serve me, my family and my children (as declared on my patient registration application for assistance.)

In addition, I/ We authorize the following programs/agencies to release information to the Tribal Health and Human Services Department in an effort to provide and facilitate assistance to my children and myself. Those programs and agencies are as follows:

1. \_\_\_ Montana State Offices of Public Assistance - (Flathead, Lake, Missoula, and Sanders County)
2. \_\_\_ DHRD - WIC, General Assistance, Voc - Rehab, TANF Cash Assistance, Dire Need, and Welfare to Work
3. \_\_\_ MT Children's Health Insurance Program (CHIP) - (eligibility status & employee health insurance info.)
4. \_\_\_ Salish Kootenai College - (credit load, student verification of attendance)
5. \_\_\_ Salish Kootenai Housing Authority - SKHA- (residency, household composition)
6. \_\_\_ Early Childhood Services - ECS, Head Start - (Chip info, address, household composition)
7. \_\_\_ Public Schools - (Verify attendance of minor children)
8. \_\_\_ S&K Electronics- (insurance coverage)
9. \_\_\_ S&K Technologies
10. \_\_\_ Social Security Administration, MT Disability Bureau, Veterans Administration
11. \_\_\_ Workman's Compensation Programs - (medical coverage)
12. \_\_\_ Tribal Education
13. \_\_\_ Tribal Enrollment (To verify membership /decendency)
14. \_\_\_ Other \_\_\_\_\_

I acknowledge that all private contract providers where I seek medical treatment approved by CS&KT may release requested medical and/or other information necessary to process my claim, necessary for quality assurance, or necessary for medical care management.

I/We understand that the information received by the Tribal Health and Human Services Department- Beneficiary Services Office will be kept confidential, used for professional purposes only in terms of facilitating services by me and my family, and will not be released to other outside programs or agencies, unless prior authorization by me, in writing, is obtained. I/We understand that I/We may cancel this Consent for Release of Information, in writing, at any time.

**I/ We acknowledge that CHS is not an entitlement program and I/ we must apply and accept all medical benefit / Alternate resource coverage.**

Print Name: \_\_\_\_\_ Sign Name: \_\_\_\_\_  
Applicant/ Parent or Guardian Applicant/Parent or Guardian Date

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
(Witness Signature Necessary Only if Applicant Cannot Sign, Uses X or Thumbprint)

Prepare the Consent for Release of Information from the date executed/signed to date of the next patient registration certification update. **(This Release of Information authorization is in effect until revoked)**

Information Requested: \_\_\_\_\_

Person Requesting Information: \_\_\_\_\_ Date: \_\_\_\_\_

Name / Agency/ Phone/ Fax

Revised 07/13/07 rll



**ARE YOU A VETERAN? YES\_\_ NO \_\_**

Service Branch (Last): \_\_\_\_\_ Service Entry Date (Last): \_\_\_\_\_  
 Service Separation Date (Last): \_\_\_\_\_ Vietnam Service Indicated? \_\_\_\_\_  
 Service Connected: \_\_\_\_\_ Claim Number: \_\_\_\_\_ Description of VA disability: \_\_\_\_\_  
 \_\_\_\_\_ Valid VA Card: \_\_\_\_\_ DD214 Available: \_\_\_\_\_

**MEDICAID INFORMATION (Please submit a copy of Medicaid card)**

Medicaid: \_\_ Yes \_\_ No Eligibility Dates: \_\_\_\_\_ Medicaid # \_\_\_\_\_  
 Passport Provider: \_\_\_\_\_ Coverage: \_\_\_\_\_ Full \_\_\_\_\_ Basic

**MEDICARE INFORMATION (Please submit a copy of Medicare Card)**

Medicare: \_\_ Yes \_\_ No Medicare # \_\_\_\_\_ Plan # \_\_\_\_\_  
 Prescription Plan Name: \_\_\_\_\_ Effective Dates For Parts A: \_\_\_\_\_ B: \_\_\_\_\_ D: \_\_\_\_\_

**PRIVATE INSURANCE (Please submit a copy of insurance information)**

Company Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of Primary Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_ S.S. # \_\_\_\_\_  
 Group Name: \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date: \_\_\_\_\_ Exp.Date: \_\_\_\_\_

**FAMILY MEMBERS COVERED:**

\_\_\_\_\_  
 \_\_\_\_\_

**PLEASE READ BEFORE SIGNING:**

**Privacy Act** of 1974 PUBLIC LAW 93-579, I UNDERSTAND THAT THE INFORMATION GIVEN BY ME AND/OR COLLECTED IS NECESSARY FOR THE Indian Health Services 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 the Tribal Health and Human Services (THHS) and Indian Health Services (I.H.S.) have 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 THHS and I.H.S. may bring a claim or cause of action against the third party for recovery of such medical expenses.

Therefore, I agree as follows:

1. To assign to the THHS and I.H.S. 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 THHS and I.H.S. 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 THHS and I.H.S. against such third person.

I hereby authorize CSKT, THHS, and I.H.S. Contract Services 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 Tribal Legal Department, 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 until revoked)**

**I certify the above information provided to be accurate and true to the best of my knowledge and authorize TRIBAL HEALTH AND HUMAN SERVICES to verify the accuracy of this application:**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: Written statements from friends/relatives are not accepted as verification. Make sure this Form is completely filled out and signed.**

NEED	REC'D	DOCUMENTS	NEED	REC'D	DOCUMENTS
		<b>Tribal Enrollment/Decendancy</b> Official Letter or Photo I.D.			<b>Birth Certificate</b> (Original or certified copy)
		<b>Social Security Card</b>			<b>Signed Release of Information</b>
		<b>Medicaid, Medicare, or Private Insurance information</b>			<b>AOB Form Completely filled out and signed</b>
		<b>2 Items for Proof of Residency</b> (rent or utility receipt, MT drivers Lic., School attendance, Voter's Registration card, Etc...)			<b>PCP Form Submitted (If CHS Eligible)</b>