



Camas Path Community Service Department
Contract Health Services (CHS)
1821 N. LeClerc Road #2, Cusick, WA 99119

PLEASE SUBMIT THE FOLLOWING WITH YOUR APPLICATION:

- Verification of Indian Blood Or;
- Certification of Indian Blood Letter from your Tribal Office Or;
- If a Descendent from your parents, you will need to supply:
 - A copy of your Certified Birth Certificate, with a copy of your enrolled parents Indian Verification.
 - A Copy of your Social Security Card;
 - A Copy of your Medical Insurance, Medicaid, Medicare, card(s).
 - Two (2) proofs of Current Residency (ex. utility bill, phone bill, drivers license)

If you have any questions, please call the Contract Health Service's Office at: (509) 447-7110 or (509) 447-7117

***** ANY CHANGES AFFECTING ELIGIBILITY MUST BE REPORTED IMMEDIATELY TO CHS INCLUDING BUT NOT LIMITED TO RESIDENCY (MUST REPORT WITHIN 10 BUSINESS DAYS) *****

CLIENT REGISTRATION

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

DATE MOVED TO THIS ADDRESS: _____ DATE OF BIRTH: _____

MARTIAL STATUS: _____ GENDER: FEMALE ____ MALE ____ BIRTH PLACE: _____

LIST ANY OTHER NAMES USED: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MOTHER'S MAIDEN NAME: _____

MOTHER'S BIRTH PLACE: _____

FATHER'S NAME: _____

FATHER'S BIRTH PLACE: _____

TRIBE ENROLLED: _____ ENROLLEMENT NUMBER: _____

TRIBE QUANTUM: _____ TOTAL QUANTUM: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____

EMPLOYED: YES NO EMPLOYER: _____

ADDRESS: _____ CITY: _____ STATE: _____

SPOUSE'S EMPLOYER: _____

ADDRESS: _____ CITY: _____ STATE: _____

INSURANCE: YES NO MEDICARE: YES NO MEDICAID: YES NO

VETERAN'S BENEFITS: YES NO

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PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT: _____

RELATION TO APPLICANT: _____ BIRTHDATE: _____ PHONE: _____

ADDRESS (IF DIFFERENT THAN APPLICANT): _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____

INSURANCE COMPANY: _____ CONTACT NUMBER: _____

GROUP NUMBER: _____ SUBSCRIBER NUMBER: _____

OTHER DEPENDANTS COVERED UNDER THIS PLAN: _____

AUTHORIZATION TO OBTAIN INFORMATION & ASSIGNMENTS OF BENEFITS

CHS MAY DISCLOSE ALL OR ANY PART OF THE PATIENT'S RECORDS TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER A CONTRACT TO THE HOSPITAL, THE PATIENT, A FAMILY MEMBER AND/OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE HOSPITAL'S CHARGES, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICE COMPANIES, INSURANCE COMPANIES, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENT'S EMPLOYER.

I HEREBY ASSIGN TO CHS SUCH INSURANCE BENEFITS (IF ANY) THAT I MAY HAVE PERTAINING TO PAYMENT FOR MEDICAL SERVICES AND SUPPLIES FURNISHED TO ME. I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY TO THE KALISPEL TRIBE OF INDIANS. I UNDERSTAND THAT THIS ASSIGNMENT APPLIES ONLY TO MEDICAL/DENTAL SERVICES AND SUPPLIES DISPENSED TO ME DURING A 12 MONTH PERIOD EFFECTIVE AS OF THE DATE LISTED BELOW.

I HAVE READ AND UNDERSTAND THE PRIVACY ACT AND AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF BENEFITS AND DO HEREBY GIVE CHS MY AUTHORIZATION TO COLLECT PAYMENTS FROM THIRD PARTIES (SUCH AS MEDICARE, MEDICAID, AND PRIMARY INSURANCE) AND VERIFY ANY INFORMATION ON THIS APPLICATION ON MY BEHALF.

APPLICANT'S SIGNATURE

DATE