

American Indian Health Service of Chicago, Inc.

Application for Medical Services

Assigned Chart # _____

If patient is under 18, this form must be completed by the parent or legal guardian.

Please present the Registration Clerk your photo identification, Tribal documentation & Insurance card(s)

Section A PATIENT DEMOGRAPHICS

Patient Name:			Patient Sex	
[Last]	[First]	[Middle]	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Other names used?	Date of Birth	Place of Birth	Social Security Number	
Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown				
Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____				
Physical Address:			Number of Children: _____ Number of people in household: _____ How long have you lived at this address? _____	
[Address]	[Apt#]	[City]	[State]	[Zip code]
Are you currently homeless? Yes/No If yes, please indicate if you are: Staying in a shelter? ____ In a transitional living arrangement? ____ Doubling Up? ____ Living on the streets? ____ Temporarily living with someone? ____				
Home Phone:	Cell Phone:	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Significant Other		
Is your physical address the same as your mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If NO, please fill out your mailing address below:				
[Address]	[Apt#]	[City]	[State]	[Zip code]
What is your primary language (the language you speak at home)?				
What other languages do you speak?				
What is your preferred language?				
Do you need an interpreter?				
What is your religious preference?				
Are you a migrant agricultural worker? Yes/No				
Are you a seasonal agricultural worker? Yes/No				
Do you have an Advance Directive? Yes/No				
If YES, is it in the form of a "Living Will" or "Power of Attorney" or "5 Wishes"? (please circle one)				
Do you have an email address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where do you access the internet?				
Home / Work / School / Clinic / Library / Community Center				
E-MAIL Address _____@_____				
We may use your Email address to send you announcements of events you may have an interest in or when attempts to reach you by phone or postal mail have failed.				

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Because American Indian Health Service of Chicago receives funding from the federal government (DHHS / Indian Health Service) to provide services to federal and state recognized tribal enrolled American Indians and their descendants, we are required to collect the following information. This information is used for statistics only, without anyone's name attached to it, and it will remain confidential. Reporting these statistics to the federal government enables American Indian Health Service of Chicago to continue to receive funding for the services we provide. Thank you for your cooperation.

Section B PATIENT TRIBAL INFORMATION		
Are you: <input type="checkbox"/> Enrolled Tribal Member [] <input type="checkbox"/> Enrollment is pending [] <input type="checkbox"/> Descendent of an Enrolled Member []	Tribe Name	Agency Where Enrolled:
Blood Quantum/Degree Amount:	Enrollment/Census #	
Are you a descendent from any other Tribe(s)? If so, please list the Tribe name and quantum here:		Total (combined) degree:
Father's Name (FILL THIS OUT <u>ONLY</u> IF DESCENDENT OF ENROLLED MEMBER)	Date of Birth	Place of Birth
[Last] _____ [First] _____ [Middle] _____		
Father's Tribal Affiliation?	Enrollment/Census #	If deceased, date of death:
Mother's Name (FILL THIS OUT <u>ONLY</u> IF DESCENDENT OF ENROLLED MEMBER)	Date of Birth	Place of Birth
[Last] _____ [First] _____ [Middle] _____		
Mother's Tribal Affiliation?	Enrollment/Census #	If deceased, date of death:

Section C EMPLOYMENT INFORMATION (PARENT/GUARDIAN INFORMATION IF PATIENT IS UNDER 18)		
Are you Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired	Other source of Income? <input type="checkbox"/> Public Assistance <input type="checkbox"/> Social Security <input type="checkbox"/> Other _____	Income: Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Yearly
Employer Name:	How long with employer?	Employer Phone #
Employer Address:		
[Address] _____	[City] _____	[State] _____ [Zip code] _____
Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Time <input type="checkbox"/> Part-time	If YES, where?	How long?
IF PARENT/GUARDIAN - RELATIONSHIP TO PATIENT (CIRCLE ONE)		
Biological Parent	Foster Parent	Relative
Other(explain) _____		

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Section D SPOUSE/SIGNIFICANT OTHER INFORMATION (OTHER PARENT/GUARDIAN INFORMATION IF PATIENT IS UNDER 18)

Spouse/Significant Other's Name		Date of Birth	Check here if spouse is deceased <input type="checkbox"/>	Is spouse/significant other American Indian? <input type="checkbox"/> NO <input type="checkbox"/> YES
[Last]	[First]	[Middle]	Tribe: _____	
Are they Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired	Other source of Income? <input type="checkbox"/> Public Assistance <input type="checkbox"/> Social Security <input type="checkbox"/> Other _____		Income: <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Yearly	
Employer Name:		How long with employer?	Employer Phone #	
Employer Address:				
[Address]	[City]	[State]	[Zip code]	
Are they a student? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full Time <input type="checkbox"/> Part-time	If YES, where?		How long?	
IF PARENT/GUARDIAN - RELATIONSHIP TO PATIENT (CIRCLE ONE)				
Biological Parent		Foster Parent		Relative
Other (explain) _____				

Section E MILITARY SERVICE

Were you ever in the service? <input type="checkbox"/> Yes <input type="checkbox"/> No	Entry Date:	Service Connected Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No
		If YES, claim # _____
If YES which Branch?	Vietnam Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Separation Date: _____	

Section F EMERGENCY CONTACT INFORMATION

PERSON WHO CAN BE CONTACTED IN THE EVENT OF AN EMERGENCY:		
Name:	Relationship:	Phone #
Address:		
[Address]	[City]	[State] [Zip code]
NEXT OF KIN (DIFFERENT FROM YOUR EMERGENCY CONTACT INFORMATION ABOVE):		
Name:	Relationship:	Phone #
Address:		
[Address]	[City]	[State] [Zip code]

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Section G INSURANCE INFORMATION (PLEASE SUBMIT COPY OF FRONT & BACK OF ANY CARD)

MEDICARE PROGRAM

Do you currently have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number: _____	What Part? <input type="checkbox"/> A-Inpatient <input type="checkbox"/> B-Outpatient <input type="checkbox"/> C-HMO <input type="checkbox"/> D-Pharmacy
Are you currently 65 years of older? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAID PROGRAM (PUBLIC AID)

Are you currently enrolled with the Medicaid Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES please give Health Plan Name and Policy Number: _____
If you are not enrolled in the local state Medicaid Program, are you enrolled in another state? <input type="checkbox"/> Yes State: _____ <input type="checkbox"/> No	If YES please give Health Plan Name and Policy Number: _____

PRIVATE INSURANCE

Are you covered by a Private Health Insurance Plan? Yes/No If Yes Policy # _____ Effective Date: _____	If YES, what is the name and address of your insurance? _____ _____ Telephone # _____	Group # _____
Who is the primary insured (policy holder?) _____		Their Date of Birth _____

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS:

American Indian Health Service of Chicago has my permission to release information as needed for insurance processing and for my insurance release payment to this clinic. I HEARBY AUTHORIZE TREATMENT

Signature of Patient or Guardian: _____

Printed Name: _____

Date: _____

Section H SLIDING FEE SCALE DISCOUNT

As a Federally Qualified Health Center and to keep our services affordable, we receive grant funding. To qualify for these resources we must collect the following information on all our clients. Please support us by providing the following documentation.

AIHSC offers a sliding fee adjustment for patients and members of their families who fall below 200% of the poverty guidelines as set forth in the Federal Register. Income levels are based on total "family" income and "family" size. The amount of the discounts and the income ranges for those discounts are fixed by the Board of Directors. Income guidelines are revised annually. A Copy of the Sliding Fee Scale Policy is available, please ask receptionist for a copy.

INCOME VERIFICATION (REQUIRED)
 Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify AIHSC of that change. AIHSC reserves the right to verify income with an employer at any time.
 Patients are required to provide income verification and to give at least 1 of the following documents:

1. Previous year tax return or W-2 form(s)
2. Current pay stubs (last 4 weeks, if possible)
3. Lay-off notice from last employer
4. Current information from Unemployment Office
5. Denied Medicaid application and reason for denial
6. Check stubs from Unemployment (last 4, if possible)

FOR OFFICE USE ONLY

Number in Family _____ Monthly Income \$ _____ or Annual Income \$ _____ Sliding Fee Discount Assigned _____

Reviewer Name and Date: _____

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Section I BENEFITS COORDINATION

Are you interested in assistance to help to see if you qualify for Expanded Medicaid or the Insurance Marketplace? Yes No

Are you in need of other social service assistance such as housing, food, etc.?

What kind of help do you need? _____

I certify that the information provided on this form is true and accurate, as of the date of the signature.
I agree to contact American Indian Health Service of Chicago, Inc. if the information on this form changes in anyway.

Patient Signature (Parent/Guardian if patient is a minor)

Date

If signature is Parent or Guardian – please PRINT name here

Section J RELEASE OF INFORMATION

In general, the HIPPA privacy rule gives individuals the right to request the restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Please check all that apply

Home Telephone	Work Telephone
Mail to home address	Mail to my work/office address
Home Fax	Work Fax
Leave message with detailed information	Work/Leave message with detailed information
Leave message with call back number only	Work/Leave message with call back number only
Written Communication	Work Address/Written Communication
Email	Work Email

The Patient Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for the PHI to the minimum, necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures information provided below.

Please indicate to whom American Indian Health Service of Chicago may release information to other than billing persons or Healthcare professionals.

Name	Telephone Number	Relationship

This agreement will remain in effect until notification, of any changes or corrections, is received by American Indian Health Service of Chicago from the patient or guardian

Patient/Guardian Signature

Print Name

Date