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: [Last] [First] [Middle]			Patient Sex ☐Male ☐Female
Other names used?	Date of Birth	Place of Birth	Social Security Number

Ethnicity [ ] Not Hispanic or Latino [ ]Hispanic or Latino [ ]Unknown

Race
[ ] American Indian/Alaskan Native [ ] Asian [ ] Black or African American [ ] Hispanic or Latino
[ ] Native Hawaiian or Pacific Islander [ ] White [ ] Other _____

Physical Address: [Address] [Apt#] [City] [State] [Zip code]	Number of Children: _____ Number of people in household: _____ How long have you lived at this address? _____

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:	Martial Status ☐Single ☐ Married ☐Divorced ☐Widow(er) ☐Significant Other

Is your physical address the same as your mailing address? ☐ Yes ☐ No

If NO, please fill our 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? ☐ Yes ☐ 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: □Enrolled Tribal Member [ ] □Enrollment is pending [ ] □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 ONLY IF DESCENDENT OF ENROLLED MEMBER) [Last] [First] [Middle]	Date of Birth	Place of Birth
Father's Tribal Affiliation?	Enrollment/Census #	If deceased, date of death:
Mother's Name (FILL THIS OUT ONLY IF DESCENDENT OF ENROLLED MEMBER) [Last] [First] [Middle]	Date of Birth	Place of Birth
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? □Yes □ No □ Retired	Other source of Income? □ Public Assistance □ Social Security □ Other _____	Income: Monthly □Weekly Bi-Monthly □ Yearly
Employer Name:	How long with employer?	Employer Phone #
Employer Address: [Address] [City] [State] [Zip code]		
Are you a student? □Yes □ No □ Full Time □ Part-time	If YES, where?	How long?
IF PARENT/GUARDIAN - RELATIONSHIP TO PATIENT (CIRCLE ONE)		
Biological Parent	Foster Parent	Relative Other(explain) _____

Section D SPOUSE/SIGNIFICANT OTHER INFORMATION (OTHER PARENT/GUARDIAN INFORMATION IF PATIENT IS UNDER 18)			
Spouse/Significant Other's Name [Last] [First] [Middle]	Date of Birth	Check here if spouse is deceased □	Is spouse/significant other American Indian? □ NO□ YES Tribe: _____
Are they Employed? □Yes □ No □ Retired	Other source of Income? □ Public Assistance □ Social Security □ Other _____	Income: □ Monthly □Weekly Bi-Monthly □ Yearly	
Employer Name:	How long with employer?	Employer Phone #	
Employer Address: [Address] [City] [State] [Zip code]			
Are they a student? □Yes □ No □ Full Time □ 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 is the service? □Yes □ No	Entry Date:	Service Connected Disability: □Yes □ No If YES, claim # _____
If YES which Branch?	Vietnam Veteran? □Yes □ 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]		

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

MEDICARE PROGRAM

Do you currently have Medicare? □Yes □ No	Medicare Number:	What Part? □ A-Inpatient □ B-Outpatient □ C-HMO □D-Pharmacy
Are you currently 65 years of older? □Yes □ No	Are you disabled? □Yes □ No	

MEDICAID PROGRAM (PUBLIC AID)

Are you currently enrolled with the Medicaid Program? □Yes □ 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? □Yes State:_____ □ 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