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: ______________________________

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AUTHORIZATION TO OBTAIN INFORMATION & ASSIGNMENTS OF BENFITS

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