Central Valley Indian Health, Inc.

DOCUMENTS REQUIRED BY CVIH IN ORDER TO VERIFY DIRECT CARE ELIGIBILITY

1. PHOTO IDENTIFICATION (for everyone 18 or older)
2. SOCIAL SECURITY CARD (for everyone)
3. COUNTY CERTIFICATE OF LIVE BIRTH (Only if documentation is not your own…need all CLB's up to the documented Native American)
4. FAMILY TREE (Only if documentation is not your own….up to the documented Native American)
5. B.I.A. LETTER OR TRIBAL DOCUMENTS (Tribal card or letter)
6. PROVIDE COPY OF ALL INSURANCE CARDS
7. MUST LIVE IN FRESNO, MADERA OR KINGS COUNTIES FOR CONTRACT CARE SERVICES.

PATIENTS MUST COMPLY WITH ALTERNATE RESOURCE REQUIREMENTS WITHIN 60 DAYS.

ALL DOCUMENTS MUST BE SUPPLIED WITHIN 60 DAYS OF THE DATE OF YOUR FIRST VISIT.

THANK YOU

2740 Herndon Avenue • Clovis, CA 93611 • Phone: 559.299.3262 • Fax: 559.862.2744

(09.20.13)

__CLOVIS ____MED __DEN
__PRATHER ____MED __DEN
__NORTH FORK____MED __DEN
__TACHI____MED __DEN

DO YOU HAVE ANY SPEICAL NEEDS?
____SIGHT ___ HEARING
____AMBULATORY
____ SPEECH

CENTRAL VALLEY INDIAN HEALTH
NATIVE AMERICAN PATIENT REGISTRATION

PATIENT INFORMATION **CHART NO:_____**
LEGAL LAST NAME: **FIRST:** **MIDDLE:**
DATE OF BIRTH: **CITY OF BIRTH:** **STATE OF BIRTH:**
SEX: **SOCIAL SECURITY NUMBER:**
MARITAL STATUS: SINGLE___ MARRIED__ DIVORCED___ WIDOWED___ SEPARATED___
STREET ADDRESS: **CITY:** **STATE:** **ZIP CODE:**
MAILING ADDRESS(IF DIFFERENT FROM STREET ADDRESS): **CITY:** **STATE:** **ZIP CODE:**
HOME PHONE# **CELL PHONE#:**
DATE MOVED TO PRESENT COMMUNITY:
INTERNET ACCESS: ___YES ___NO **WHERE:_____** **E-MAIL ADDRESS:_____**
EMPLOYMENT STATUS: ___UNEMPLOYED ___FULL-TIME ___PART-TIME ___ACTIVE MILITARY DUTY (SELF OR PARENTS FOR CHILDREN) **___SELF EMPLOYED ___RETIRED ___DISABLED ___STUDENT**
NUMBER IN HOUSEHOLD_____ **MONTHLY INCOME_____**
EMPLOYMENT INFORMATION FOR YOURSELF *(OR PARENT'S INFORMATION FOR CHILD 18 & UNDER)*
EMPLOYER NAME: *(FATHER'S FOR CHILD)*
EMPLOYER STREET/MAILING ADDRESS:
CITY: **STATE:** **ZIP CODE:** **PHONE NUMBER:**
SPOUSE EMPLOYER NAME: *(MOTHER'S FOR CHILD)*
EMPLOYER STREET/MAILING ADDRESS:
CITY: **STATE:** **ZIP CODE:** **PHONE NUMBER:**
ETHNICITY(GROUP ASSOCIATION): **___ DECLINED TO ANSWER ___HISPANIC OR LATINO** **___NOT HISPANIC OR LATINO ___UNKNOWN BY PATIENT**
RACE (BIOLOGICAL): **___INDIAN/ALASKAN NATIVE ___HISPANIC OR LATINO ___ BLACK OR AFRICAN AMERICAN** **___ NATIVE HAWIIAN OR OTHER PACIFIC ISLANDER ___WHITE ___ASIAN ___FILIPINO** **___DECLINED TO ANSWER ___UNKOWN BY PATIENT**
PRIMARY LANGUAGE:_____ PROFICENCY: ___VERY WELL ___WELL ___NOT WELL ___NOT AT ALL
OTHER LANGUAGES SPOKEN: _____ PREFERRED LANGUAGE:_____
MIGRANT WORKER: ___ YES ___ NO IF YES, SEASONAL OR MIGRANT AGRICULTURAL WORKER
HOMELESS: ___ YES ___ NO SHELTER: ___ YES ___NO
ELIGIBILITY/RELIGION/TRIBAL DATA
RELIGIOUS PREFERENCE (OPTIONAL):
TRIBE OF MEMBERSHIP:
INDIAN BLOOD QUANTUM:
FATHER'S NAME:
FATHER'S CITY & STATE OF BIRTH: **TRIBE:**
MOTHER'S NAME: **MOTHER'S MAIDEN NAME:**
MOTHER'S CITY AND STATE OF BIRTH: **TRIBE:**
TRIBE STREET/MAILING ADDRESS: **CITY:** **STATE:** **ZIP CODE:**
PLEASE PROVIDE COPY OF TRIBAL VERIFICATION (TRIBAL ID CARD, LETTER FORM BIA, ETC.)

__CLOVIS ____MED __DEN
__PRATHER ____MED __DEN
__NORTH FORK____MED __DEN
__TACHI____MED __DEN

DO YOU HAVE ANY SPEICAL NEEDS?
____SIGHT ___ HEARING
____AMBULATORY
____ SPEECH

CENTRAL VALLEY INDIAN HEALTH
NATIVE AMERICAN PATIENT REGISTRATION

EMERGENCY CONTACT (IF FOR A CHILD, PLEASE FILL- IN PARENT/GUARDIAN NAME)		
EMERGENCY CONTACT NAME:		
EC PHONE:	**EC RELATIONSHIP:**	
EC ADDRESS-STREET:		
EC ADDRESS-CITY:	**STATE:**	**ZIP CODE:**
NEXT OF KIN: (ENTER SAME IF SAME PERSON AS EMERGENCY CONTACT)		
NOK NAME:	**NOK RELATIONSHIP:**	
NOK PHONE:		
NOK ADDRESS-STREET:		
NOK ADDRESS-CITY:	**STATE:**	**ZIP CODE:**
INSURANCE INFORMATION		
DO YOU HAVE MEDICARE? YES___ NO___	**DO YOU HAVE MEDI-CAL? YES___ NO___**	
DO YOU HAVE PRIVATE INSURANCE? YES___ NO___		
INSURANCE NAME:	**POLICY#**	**SUBSCRIBER:**
SUBSCRIBER'S DOB:		**SOC. SEC. NUMBER:**
ATTACH COPY OF MEDI-CAL, MEDI-CARE OR INSURANCE CARDS	**CLAIM NUMBER:**	
VETERAN INFORMATION		
VETERAN.S INFORMATION: VETERAN ___YES ___NO	**SERVCE BRANCH (LAST)?**	
SERVICE ENTRY DATE (LAST)?	**SERVICE SEPARATION DATE (LAST)?**	
SERVICE CONNECTED?	**DESCRIPTION OF VA DISABILITY:**	
VALID VA CARD?	**ASSIGNMENT AND RELEASE**	

AUTHORIZATIONS FOR RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION, INCLUDING DIAGNOSIS OF A MEDICAL CONDITION FOR THE SOLE PURPOSE OF SUBMISSION OF CLAIMS TO THIRD PARTY BILLING INSURANCE CARRIERS. I FURTHER AUTHORIZE CENTRAL VALLEY INDIAN HEALTH TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESS OF THIS CLAIM. I HERBY ASSIGN ANY INSURANCE BENEFITS TO CENTRAL VALLEY INDIAN HEALTH AND AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CENTRAL VALLEY INDIAN HEALTH. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE DEDUCTIBLE, CO-PAYMENT AND CHARGES NOT COVERED BY SAID INSURANCE OR GOVERNMENT AGENCY.

I HEREBY DECLARE THAT I HAVE READ THE PATIENT REGISTRATION FORM, AND KNOW AND UNDERSTAND THE CONTENTS THEREOF AND THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN: ***DATE:***

OFFICE USE ONLY:

RECEIVED INSURANCE CARD: YES NO	RECEIVED INDIAN VERIFCIATION: YES NO
TYPE OF VERIFICATION:	
ENTERED INTO SYSTEM ON:	ENTERED BY:
APPROVED FOR (CIRCLE ONE) DC CC	REGISTRATION COMPLETE: YES NO

MISSING DOCUMENTS:

(REV. 09/20/13)

CVIH FAMILY TREE

DATE:_____

_____
Applicant's Name

_____
Date Of Birth

_____
Current Home Adress

_____
State,Zip Code

_____
Phone Number

Is Applicant Adopted?
☐ Yes ☐ No

Are Parent'S Adopted
☐ Yes ☐ No

If yes, List Biological parents:

_____

_____

Attach copy of your live Birth Certificate

FATHER
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____
Date of Birth:_____

MOTHER (Maiden Name)
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____
Date of Birth:_____

Paternal Grandfather
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____
Date of Birth:_____

Paternal Grandmother (maiden Name)
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____
Date of Birth:_____

Maternal Grandfather
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____
Date of Birth:_____

Maternal Grandmother (maiden Name)
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____
Date of Birth:_____

Paternal Great Grandfather:
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____

Paternal Great Grandmother:
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____

Paternal Great Grandfather:
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____

Paternal Great Grandmother:
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____

Maternal Great Grandfather:
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____

Maternal Great Grandmother:
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____

Maternal Great Grandfather:
Name:_____
Tribe:_____
Roll:_____
Deceased: ☐ YES ☐ No Year:_____

Maternal Great Grandmother:
Name:_____
Tribe:_____
Roll:_____

ATTACHMENT A

CENTRAL VALLEY INDIAN HEALTH, INC.
2740 HERNDON AVE, CLOVIS CA 93611
(559) 299.3262 XT 1811

PATIENT REQUIREMENT FOR
ALTERNATE RESOURCE DETERMINATION

DATE: _____ DATE OF BIRTH:_____

PATIENT NAME: _____

ADDRESS:_____CITY/STATE/ZIP:_____

HM. PHONE:_____ CELL: _____

This information is necessary pursuant to Indian Health Service Regulations, 42 CFR, Subpart G, Paragraph C. You must provide this facility with a copy of the alternate resource's eligibility determination.

PLEASE CHECK THE LINE THAT PERTAINS TO YOU THE PATIENT:

YES_____ NO____ Do you have Covered California

YES _____ NO____ Do you have Medi-Cal?

YES _____ NO____ Do you have Medicare?

YES _____ NO____ Do you have private health insurance, including Kaiser Insurance?

YES _____ NO____ Do you have CMSP from Fresno, Madera or Kings County?

- If you answered **YES** to any of the above questions, please give your card to the Medical Receptionist to copy for your file.
- If you answered **NO** to all of the above questions, you will need to be screened by the Patient Services Representative at 299.3262 XT 1811. You can also apply at the Social Services Office in the county you reside.
- If you are employed, we need a statement from your employer stating that you do not have medical insurance.
- If you need assistance, please contact the CVIH Patient Services Representative. You will have 60 days to complete the necessary information and return it to the CHS/Eligibility Office. If no information is returned, and there is no request for assistance, a CHS denial letter will be issued.

Sincerely,

CENTRAL VALLEY INDIAN HEALTH

(09.20.13)

FOR OFFICE USE ONLY

_____

PATIENT SERVICES REP. DATE

CENTRAL VALLEY INDIAN HEALTH, INC

PATIENT RIGHTS & RESPONSIBILITIES

Thank you for choosing Central Valley Indian Health, Inc. as your primary health care provider. We look forward to serving you in the most thorough and professional manner possible. As we enter into this healing partnership, we would like to emphasize the fact that you have certain rights and responsibilities as our patient. These rights and responsibilities help ensure an environment where true healing can take place. By being informed yourself and by keeping your provider informed on matters pertaining to your health, both you and the provider can work toward a common goal – preservation of health. With this *partnership in healing* concept in mind:

You have the right to:

1. Be treated with respect, consideration and dignity.
2. Be provided appropriate privacy.
3. Have your disclosures and records treated confidentially, and except when required by law, given the opportunity to approve or refuse their release.
4. Be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
5. Be given the opportunity to participate in decisions involving your health care, except when such participation is contraindicated for medical reasons.
6. Change your provider if another qualified CVIH provider is available.
7. File suggestions, complaints or grievances when you feel your rights have not been met. All suggestions, complaints and grievances should be reported to the Director of the Department you wish to discuss.
8. Request information regarding your health care professionals' credentials.

You have a responsibility to:

1. Provide complete and accurate information to the best of your ability about your health, any medications, including over-the-counter products, dietary supplements and any allergies or sensitivities.
2. Follow the treatment plan prescribed by your provider.
3. Provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider.
4. Inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
5. Accept personal financial responsibility for any charges not covered by your insurance or CVIH.
6. Be respectful of all the health care providers and staff, as well as other patients.
7. Be sure you understand all oral and written instructions given by a CVIH provider.
8. Report any changes in your health.
9. Keep appointments or cancel at least 24 hours in advance.
10. Provide CVIH with current Medi-Cal, private insurance or other third party payer information at the time services are rendered.
11. Make payment for services provided on the day of your visit unless prior arrangements have been made.

As a partner in the healing process, I have read and understand The CVIH Patient Rights & Responsibilities.

_____ _____

Patient Signature Date

(09.20.13)