CENTRAL VALLEY INDIAN HEALTH, INC.
PATIENT ELIGIBILITY PACKET

2740 Herndon Ave Clovis, CA 93611 Phone 559.299.3262 Fax 559.862.2744

PATIENT REGISTRATION FORM

Central Valley Indian Health, Inc.

Legal Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ City of Birth: _____ State of Birth: _____

Social Security Number: _____ Sex: ☐Male ☐Female ☐Other_____

Marital Status:☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home Address: _____ City: _____ State: _____ Zip code: _____

Mailing Address: _____ City: _____ State: _____ Zip code: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____ Do you accept text messages:☐Yes ☐No

Date moved to present community: _____ Internet Access:☐Yes ☐No

Employment Status: ☐Full-Time ☐Part-Time ☐Self-Employed ☐Unemployed ☐Retired ☐Other: _____

Race:☐Indian/Alaskan Native ☐White ☐Asian ☐Black ☐Hispanic ☐Other: _____

Ethnicity:☐Hispanic ☐Non-Hispanic ☐Other: _____ Language:☐English ☐Spanish ☐Other: _____

Do you have any special needs:☐Sight ☐Hearing ☐Ambulatory ☐Speech ☐Other: _____

Preferred Pharmacy Name and Location: _____

Responsible Party: ☐**Self** ☐**Spouse** ☐**Parent/Guardian** ☐**Other:** _____

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Address: _____ Relationship: _____

Next of Kin Contact Name: _____ Phone Number: _____

Address: _____ Relationship: _____

PARENTAL INFORMATION *(Complete only if application is for a child/minor)*

Father's Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone Number: _____

Employer Name: _____

Mother's Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone Number: _____

Employer Name: _____

ELIGIBILITY - RELIGION - TRIBAL INFORMATION

Religious Preference: _____

Tribe of Membership: _____ **Indian Blood Quantum:** _____

Tribe Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

Name of Reservation: _____

Other Tribe Information: _____

Father's Name: _____

Father's City & State of Birth: _____ Tribe: _____

Mother's Name: _____ Mother's Maiden Name: _____

Mother's City & State of Birth: _____ Tribe: _____

Central Valley Indian Health, Inc.

INSURANCE INFORMATION

Type of Insurance: ☐ Medi-Cal ☐ Medicare ☐ Private Insurance/PPO ☐ Other: _____
Insurance Name: _____
Policy Number: _____ Subscriber Number: _____
Date of Birth: _____ Social Security Number: _____

Secondary Insurance

Type of Insurance: ☐ Medi-Cal ☐ Medicare ☐ Private Insurance/PPO ☐ Other: _____
Insurance Name: _____
Policy Number: _____ Subscriber Number: _____
Date of Birth: _____ Social Security Number: _____

VETERAN INFORMATION

Are you a Veteran: ☐ Yes ☐ No Do you have a valid VA Card: ☐ Yes ☐ No
Service Branch (Last): _____ Service Entry Date (Last): _____
Service Separation Date (Last): _____ Vietnam Service Indicated: ☐ Yes ☐ No
Service Connected: ☐ Yes ☐ No Claim Number: _____
Description of VA Disability: _____

ASSIGNMENT AND RELEASE

AUTHORIZATION 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 hereby 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.

Patient/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

*****PLEASE ATTACH ALL DOCUMENTS REQUIRED BY CVIH IN ORDER TO VERIFY ELIGIBILITY*****

************* OFFICE USE ONLY *************

REGISTRATION COMPLETE: ☐ YES ☐ NO
ID CARD RECEIVED: ☐ YES ☐ NO
INSURANCE CARD RECEIVED: ☐ YES ☐ NO
TRIBAL VERIFICATION RECEIVED: ☐ YES ☐ NO
TYPE OF VERIFICATION: _____
FEE SCHEDULE: ☐ CONTRACT CARE ☐ DIRECT CARE ☐ CVIH STAFF ☐ CVIH STAFF FAMILY ☐ NON-INDIAN ☐ PRIVATE PAY ☐ SLIDING FEE ☐ VETERAN ☐ PENDING VERIFICATION
SERVICE ELIGIBILITY: ☐ CONTRACT CARE ☐ DIRECT CARE ☐ INELIGIBLE ☐ PENDING
TRIBE NAME: _____ BLOOD QUANTUM: _____
BENEFICIARY CLASSIFICATION: ☐ INDIAN/ALASKAN NATIVE ☐ NON-INDIAN EMERGENCY ☐ NON-INDIAN ELECTIVE ☐ NON-INDIAN DEPENDENT ☐ NON-INDIAN FEE CHARGED
COMMUNITY OF RESIDENCE: _____
CVIH SITE: ☐ CLOVIS MEDICAL ☐ CLOVIS DENTAL ☐ TACHI MEDICAL ☐ TACHI DENTAL ☐ NORTH FORK ☐ PRATHER MEDICAL ☐ PRATHER DENTAL ☐ BULLARD ☐ BHS
VERIFIED AND ENTERED BY: _____ DATE: _____
MISSING DOCUMENTS/NOTES: _____

DOCUMENTS REQUIRED BY CVIH IN ORDER TO VERIFY ELIGIBILITY

Patients must comply with alternate resource requirements within **30 days.**

ALL PATIENTS

- ☐ CVIH Patient Registration Form
- ☐ Photo ID Card (all applicants 18 yrs. +)
- ☐ Social Security Number
- ☐ Insurance Card(s)
  - Copy of private insurance card
  - Medi-Cal card
  - Medicare card
- ☐ Alternate Resource Determination Form

DIRECT CARE PATIENTS

- ☐ All the above documents, including those listed below
- ☐ County Certificate of Live Birth (only if you are applying for someone other than yourself)
  - Need all CLB's up to the documented Native American
- ☐ Family Tree (only if you are applying for someone other than yourself)
  - Up to the documented Native American
- ☐ Bureau of Indian Affairs (BIA) Letter or Tribal Documents
  - Tribal Card/Letter

PURCHASED REFERRED CARE PATIENTS

****MUST LIVE IN THE FRESNO, MADERA OR KINGS COUNTY FOR PURCHASED REFERRED CARE SERVICES****

- ☐ All the above documents, including those listed below
- ☐ Purchased Referred Care Notification of Pharmacy Benefits Form
- ☐ CVIH Purchased Referred Care Referral Guide Form

For additional information, please visit our website at: www.cvih.org

Central Valley Indian Health, Inc.

PATIENT REQUIREMENT FOR ALTERNATE RESOURCE DETERMINATION

Date: _____

Patient Name: _____Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____

This information is necessary pursuit to Indian Health Services Regulations, 42 CFR, Subpart G, paragraph C. You must provide this facility with a copy of the alternate resource's eligibility determination. Please answer all items below.

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?	☐YES ☐NO
Do you have private Kaiser insurance?	☐YES ☐NO

- If you answered YES to any of the above question, please provide a copy of your insurance card to our office.
- If you recently applied for Medi-Cal and were denied, please provide us with a copy of the denial.
- If you answered NO to all of the above questions and have not applied and received a denial for Medi-Cal within the past 12 months, you will need to be screened by a Patient Service Representative for alternate resources. Please call 299-3262 Ext. 1810 or 1811 for further assistance.
- You may also apply at the Social Service office in the county where you reside, online, or with our Patient Services Representative.
- If you are employed, we need a statement from your employer stating that you do not have medical insurance.

❖ The form can be mailed to 2740 Herndon Ave Clovis, CA 93611; or
❖ Email to: eligibility@cvih.org; or
❖ Upload documents to www/cvih.org/eligbility - it is at the bottom of the page

*****If you need assistance, please contact a CVIH Patient Services Representative at 559-299-3262 ext. 1810 or 1811. You have 30 days to complete the necessary information and return this to the Eligibility Office. If required document(s) are not submitted and there is no request for assistance, a denial letter will be issued*****

Central Valley Indian Health, Inc.

FAMILY TREE

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____

Are you/patient adopted: ☐YES ☐NO Are you/patient parents adopted: ☐YES ☐NO If yes, list biological parents: _____

Father
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Paternal Grandfather
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Paternal Great Grandfather
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Paternal Great Grandmother
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Paternal Grandmother
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Paternal Great Grandfather
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Paternal Great Grandmother
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Mother
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Maternal Grandfather
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Maternal Great Grandfather
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Maternal Great Grandmother
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Maternal Grandmother
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Maternal Great Grandfather
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

Maternal Great Grandmother
Name: _____
Tribe Name: _____
Roll #: _____
Date of Birth: _____
Deceased: Yes Year: _____ **/ No**

PURCHASED REFERRED CARE PATIENT NOTIFICATION OF PHARMACY BENEFITS

Central Valley Indian Health, Inc. has identified you as being Purchased Referred Care (PRC) eligible (your status may still be pending final review by the Eligibility Committee). As a PRC eligible patient, you are eligible for pharmacy benefits. Pharmacy benefits are only good at contracted pharmacies below:

CVS PHARMACY
29412 Auberry Road
Prather, CA 93651
PH: 559-855-4220

THE MEDICINE SHOPPE
195 W. Shaw, Suite 101-A
Clovis, CA 93612
H: 559-297-0251

CVS PHARMACY
1405 Herndon Ave
Clovis, CA 93611
PH: 559-322-1574

RALEY'S OAKHURST
40041 Highway 49
Oakhurst, CA 93644
PH: 559-683-8300

CVS PHARMACY
574 W. Lacey Blvd
Hanford, CA 93230
PH: 559-582-2875

As a PRC eligible patient, you are obligated to notify CVIH staff, contracted pharmacies and specialty providers of any Medi-Cal, Medicare Part D, private insurance or other insurance coverage that you may have. Your pharmacy benefits at CVIH will work with whichever pharmacy benefits your insurance may offer. If you have any questions about your pharmacy benefits, please contact a PRC Representative at 559-299-3262 ext. 1812 or ext. 1811 or ext. 1810.

Patient Name: _____Date of Birth: _____

Do you have insurance (Mark One): ☐Yes / ☐No If yes, list insurance: _____

I plan to use the _____ pharmacy.

I certify that the information listed above is true and correct. I agree to notify CVIH in the event that there is any change to my insurance coverage. I also give CVIH permission to notify CVIH Contract pharmacies of Pharmacy ID# and insurance information.

_____ _____ _____ _____
Patient Signature Date CVIH Representative Signature Date

_____ _____ _____
Parent/Guardian Signature Date Parent/Guardian Name

Pharmacy ID# CVIH_____
Effective Date _____
CC: Eligibility File Pharmacy

IMPORTANT NOTICE FOR MEDICARE BENEFICIARIES
FOR PURCHASED REFERRED CARE SERVICES

Subject: Your Prescriptions Drug Plan (PDP) coverage under Medicare Part D and the Annual Credible Coverage Letter (42 CFR 423.56)

IHS has obtained authorization from CMS to discontinue the annual Creditable Coverage Notification letter sent to you each year. IHS is considered a Creditable Coverage provider and you as an IHS beneficiary are considered to have creditable coverage. What this means is that if you should decide to enroll in Medicare Part D, you may enroll in a Medicare Prescription Drug Plan (PDP) *without incurring a late enrollment penalty*. If you enroll in a PDP, you will be able to obtain a creditable coverage letter from your local IHS service unit. This letter can be used to verify that you are an IHS beneficiary and that you have a creditable prescription drug coverage.

For additional information, you can also go to the Patient Service Representative at Central Valley Indian Health or contact out office for further information by calling 559-299-3236 ext. 1810 or 1811. You may also contact Medicare at 1-800-MEDICARE (1-800-633-4227) or go to visit the website at www.medicare.gov TTY users should call 1-877-486-2048.

CENTRAL VALLEY INDIAN HEALTH PURCHASED REFERRED CARE REFERRAL GUIDE

Before any referral is made, a CVIH Patient Services Representative must determine if you are eligible for any other coverage, including but not limited to, Medicare, Medi-Cal, or private insurance, etc.

When a patient is referred to an outside specialist by a CVIH medical or dental provider for covered services, and then again referred out to another specialist by that specialist, you must contact your CVIH medical or dental provider or referral representative.

For optical, covered services are limited to:

- Eye Exam (for contacts or glasses/not both)
- Reimbursement (for contacts or glasses/not both) up to $200.00 Annually

Any charges or fees over these amounts are the patient's responsibility.

Each specialist has their own appointment policies and procedures. Some specialists may charge fees for no-show, missed, cancelled/late cancelled or rescheduled appointments. CVIH will not cover these charges - you are responsible for these fees. After three no–show or late appointment cancellations, specialists may also disengage you from any further services at their facility. Emergency in-patient services are not covered. If you have any questions, please contact a Patient Service Representative at (559) 299-3262 ext. 1810 or 1811.

Patient Name: _____ Date of Birth: _____

_____ _____
Patient Signature Date

_____ _____
Patient Parent/ Guardian Signature Date

Parent/Guardian Name: _____

_____ _____
CVIH Representative Signature Date

Central Valley Indian Health, Inc.

CENTRAL VALLEY INDIAN HEALTH
PATIENT RIGHTS AND 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 expect 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 healthcare, except when such participation is contraindicated for medical reasons.
6. Change your provider if another qualified CVIH provider is available.
7. File suggestions, complains 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 professional's 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 or any 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 AND RESPONSIBILITIES.

SIGNATURE: _____ DATE: _____

CENTRAL VALLEY INDIAN HEALTH TELEHEALTH SERVICES CONSENT FORM

The purpose of this form is to obtain your consent for a telehealth visit with one of our healthcare providers at Central Valley Indian Health, Inc. Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical, dental and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided.*
- *It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit. I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

I understand that my healthcare provider may choose to forward my information to authorized third parties, i.e., insurance providers, pharmacies, and or other specialists, etc. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications. I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community. To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit. I certify and have reviewed the nature of this agreement and fully understand and give my consent for telehealth services at Central Valley Indian Health, Inc.

_____ _____

Print Name Date of Birth

_____ _____

Patient/Parent Signature Date

CENTRAL VALLEY INDIAN HEALTH

CONFIDENTIAL YEARLY PATIENT CONSENT TO TREATMENT AND RX HISTORY

THE UNDERSIGNED PATIENT CONSENTS TO AUTHORIZE OUR PHYSICIAN TO ADMINISTER AND PERFORM ANY AND ALL EXAMINATION, TREATMENT, DIAGNOSIS PROCEDURES AND IMMUNIZATIONS AGAINST DISEASE WHICH NOW OR DURING THE COURSE OF PATIENTS CARE ARE DEEMED ADVISABLE.

THE UNDERSIGNED PATIENT AND/OR RESPONSIBLE GUARDIAN OF A MINOR PATIENT FURTHER UNDERSTAND THAT THE MID-LEVEL PRACTITIONER MAY PROVIDE SERVICES TO THE PATIENT UNDER THE DIRECTION AND SUPERVISION OF OUR PHYSICIAN. THE MID-LEVEL PRACTITIONER (FAMILY NURSE PRACTITIONER, PHYSICIAN ASSISTANT) ARE INDIVIDUALS WITH ADDITIONAL PREPARATION IN PRIMARY HEALTH CARE, THE MID-LEVEL PRACTITIONER ARE RESPONSIBLE FOR WORKING UNDER A STANDARDIZED SET OF PROTOCOLS WHICH ALSO IDENTIFIES A PHYSICAL PRECEPTOR.

THE UNDERSIGNED PATIENT CONSENTS TO AUTHORIZE CENTRAL VALLEY INDIAN HEALTH, INC. TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA THE RXHISTORY SERVICE. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE OTHER UNAFFILIATED MEDICAL PROVIDERS, INSURANCE COMPANIES, AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PHYSICIAN, MID-LEVEL PRACTITIONERS AND/OR STAFF AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SIX MONTHS.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE SCOPE OF MY CONSENT FOR TREATMENT AND THAT I AUTHORIZE THE ACCESS TO MY RXHISTORY.

SIGNATURE: _____ DATE: _____