



**CENTRAL VALLEY INDIAN HEALTH, INC.  
PATIENT ELIGIBILITY PACKET**



### PATIENT REGISTRATION FORM

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: \_\_\_\_\_



**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 TRIBAL VERIFICATION RECEIVED:  YES  NO  
ID CARD RECEIVED:  YES  NO TYPE OF VERIFICATION: \_\_\_\_\_  
INSURANCE CARD RECEIVED:  YES  NO  
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](http://www.cvih.org)

## PATIENT REQUIREMENT FOR ALTERNATE RESOURCE DETERMINATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

This information is necessary pursuant 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](mailto:eligibility@cvih.org); or

❖ Upload documents to [www/cvih.org/eligibility](http://www/cvih.org/eligibility) - 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\*\*\***

## 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: \_\_\_\_\_

<p><b>Father</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Paternal Grandfather</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Paternal Great Grandfather</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Paternal Great Grandmother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>
<p><b>Mother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Paternal Grandmother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Paternal Great Grandfather</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Paternal Great Grandmother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>
<p><b>Mother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Maternal Grandfather</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Maternal Great Grandfather</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Maternal Great Grandmother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>
<p><b>Mother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Maternal Grandmother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Maternal Great Grandfather</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>	<p><b>Maternal Great Grandmother</b></p> <p>Name: _____          Tribe Name: _____          Roll #: _____          Date of Birth: _____          Deceased: Yes Year: _____ / No</p>





## 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](http://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, Inc.

## **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: \_\_\_\_\_