YELLOWHAWK
TRIBAL HEALTH CENTER
ELIGIBILITY OFFICE

+ Yellowhawk Tribal Health Center
46314 Timíne Way
Pendleton, OR 97801

+ P 541.966.9830
+ F 541.240.8760
+ www.yellowhawk.org

Dear applicant:

This letter is in regard to your request for an application for Tribal Health Care Services. We are currently a Tribal Health Facility, but utilize Federal Regulations to assess eligibility.

Each question on the registration form should be answered as completely as possible. It is important that any available alternate resources be listed such as private insurance, Medicare, Medicaid (Oregon Health Plan, HMO, public assistance, ADC,) or workers compensation. **A copy of your card is requested.**

If you do not have any health insurance, we are requesting that you apply for Oregon Health Plan (If you are an Oregon State Resident). You can request that an application packet be mailed to you by calling (800) 359.9517. If you have any questions regarding the application please call our office and we will assist you in any way that we can.

The application has information on the reverse side regarding the Privacy Act of 1974 and Statement of Maintenance of Health records. **Your signature is required on both sides of the application form.**

You will need to submit the following with the completed application:

- **Proof of Native American Descent (Certificate of Indian Blood or a Tribal ID card)**
- **Copy of state issued Birth Certificate**
- **Copy of Social Security Card**
- **Proof of Residency –both a mailing and a physical address are required on the application**

Your eligibility for benefits through Yellowhawk Tribal Health Center is determined by the information entered on the application

Sincerely,

Eligibility Coordinators for Yellowhawk Tribal Health Center

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ACKNOWLEDGEMENT OF SERVICES

As a patient of Yellowhawk Tribal Health Center (Yellowhawk) I understand I am eligible for **Direct Care Only.**

It has been explained to me that these are most services provided within the walls of Yellowhawk.

By signing this form, I understand and acknowledge that should my Yellowhawk provider need to send me for care outside of Yellowhawk for testing (i.e. Lab/X-Ray) or any specialty care, I am financially responsible to pay for these services. Yellowhawk Tribal Health Center will not be held financially responsible.

Should I have any questions about my eligibility or services, I understand I can call 541.966.9830 or email to _____ for clarification.

_____
PRINT PATIENT NAME

_____
Signature

Date Signed:_____

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TRIBAL HEALTH CENTER

ELIGIBILITY DEPARTMENT - PATIENT REGISTRATION FORM
46314 TIMINE WAY, PENDLETON, OR 97801
PHONE: 541.966.9830 FAX: 541.240.8760

UPDATED: 06/01/2020

PATIENT'S FULL LEGAL NAME:			
SEX:	**DATE OF BIRTH:**	**SOCIAL SECURITY NUMBER:**	**CHART NUMBER:**
INDIAN OR NON-INDIAN:	**TRIBE OF MEMBERSHIP:**	**ENROLLMENT #:**	
INDIAN BLOOD QUANTAM	**TRIBE BLOOD QUANTAM**	**OTHER TRIBE:**	
PRESENT COMMUNITY	**DATE MOVED TO COMMUNITY**	ELIGIBILITY STATUS	
MARITAL STATUS	**CITY/STATE OF BIRTH**	**EMAIL**	
STREET ADDRESS:		**PHONE:**	**ALIAS**
EMPLOYER:	**WORK PHONE:**	**PART-TIME/FULL TIME**	
MEDICARE/ID	MEDICAID/ID	RAILROAD RETIREMENT/ID	
PRIVATE INS/ID/GROUP #	***Please provide a copy of all current insurance cards***	RELIGIOUS PREFERENCE:	
FATHER'S NAME:	FATHER'S CITY & STATE OF BIRTH:	FATHER'S EMPLOYER	
MOTHER'S MAIDEN NAME:	MOTHER'S CITY & STATE OF BIRTH:	MOTHER'S EMPLOYER	
EMERGENCY CONTACT:	PHONE: ADDRESS:	RELATIONSHIP:	
NEXT OF KIN:	PHONE: ADDRESS:	RELATIONSHIP:	
HAVE YOU EVER SERVED IN THE ARMED FORCES?	ENTERY/EXIT DATE:	VIETNAM:	VA CARD:
ETHNICITY:	RACE:	NUMBER IN HOUSEHOLD:	

- AND AUTHORIZE YELLOWHAWK TRIBAL HEALTH CENTER TO VERIFY THE ACCURACY OF THIS APPLICATION.
- I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO YELLOWHAWK TRIBAL HEALTH CENTER FOR SERVICES FURNISHED TO ME BY YELLOWHAK PROVIDERS
- I AUTHORIZE YELLOWHAWK TRIBAL HEALTH CENTER AND YELLOWHAWK PROVIDERS TO RELEASE ANY MEDICAL INFORMATION NECESSARY FOR DIAGNOSIS AND FURTHER TREATMENT, OR OTHER INFORMATION TO PROCESS THIS CLAIMS.

APPLICANT'S SIGNATURE DATE

OFFICE USE ONLY

ELIGIBILITY DEPARMENT

RECEIVED BY:_____DATE:_____ ENTERED BY:_____DATE:_____ ELIGIBILITY:_____DATE:_____

PRIVACY ACT OF 1974

STATEMENT FOR MAINTENANCE OF HEALTH RECORDS

The purpose for requesting your personal medical history is to obtain information necessary for effective medical treatment. Your medical record contains what you tell the health care provider is wrong with you or how you feel. The health care provider writes (into your record) your family medical history as you answer the questions. Your answers could have an effect on the type of care you receive. Therefore, it is in your best interest to provide complete and correct information so that we will be able to carry out our responsibility of providing your proper care. The results of your physical examination, laboratory tests, medications, treatments, or surgical procedures you receive in Indian Health Service facilities are recorded in you medical record. Certain information is stored in the IHS Data System for statistical purposes.

Indian Health Service personnel may not reveal the contents of your record without your written permission, except when they are permitted to do so by law. Examples of situations where we will release information without your prior written consent are:

1. Pursuant to the order of court of competent jurisdiction
2. Certain medical condition s (primarily communicable diseases) that must be reported to various health departments and other health statistical gathering centers
3. To qualified organizations which provide health services to American Indians and Alaska Native for the purpose of planning for or providing such services, to conduct research and evaluation studies. To report to state agencies as required by state law, to prepare for litigation on behalf of the federal government.
4. To third parties (other than the Indian Health Service) responsible for the payment of medical expenses incurred by the patient while being treated by the IHS medical staff or private providers under contract with the Indian Health Services.

Public Laws 83-568, 85-151, and 93-222 give the Indian Health Service the authority to collect and maintain health records. For comprehensive list of situations in which IHS may release information from your records without your permission, you should see the Department of Health and Human Services Annual Publication of System of Records which is published annually in the Federal Register.

I have read and understand the Privacy Act information and do hereby give Yellowhawk Tribal Health Center my authorization to collect payment from third parties (such as Medicare, Medicaid, Private Insurance, etc) on my behalf.

Applicant Signature	Date	Authorizing Official	Date

Office use only

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we ***may not be allowed*** to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Yellowhawk Tribal Health Center (Yellowhawk). A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Patient Signature / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO THE FOLLOWING INFORMATION:
(Please Check Those That Apply)

☐ Medical ☐ Dental ☐ Behavioral Health ☐ Patient Account ☐ All Health Information

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone (when available)
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone (when available)
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message (when available)
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that Yellowhawk may recommend products or services to promote your improved health. Yellowhawk may or may not receive third party payment from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As a Yellowhawk Representative, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Yellowhawk Representative

YELLOWHAWK
TRIBAL HEALTH CENTER

Consent for Release of Medical Records Use & Disclosure of Protected Health Information FROM A THIRD PARTY

I, _____/_____ hereby authorize Yellowhawk Tribal Health Center to use and disclose:
(Name of Patient) (Date of Birth)

☐ Send the most recent records (1 year)
☐ Date specific Portions of my Medical or Dental Record:
From Date: _____ To Date: _____
☐ Other (specify) _____

I acknowledge that Yellowhawk Tribal Health Center, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law, will release my specified medical or dental records to the party listed above. I have reviewed Yellowhawk's NOPP and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms.
A copy of this signed and dated consent shall be as effective as the original. I release, hold harmless and agree to indemnify Yellowhawk, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent. I specifically authorize Yellowhawk to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP:

Initial where appropriate:
_____ HIV records (including HIV test results) and sexually transmissible diseases
_____ Alcohol and substance abuse diagnosis and treatment records
_____ Psychotherapy records
_____ Not Applicable

From: Facility/Provider: _____
Address/City/State: _____
Phone: _____ Fax: _____

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. **Please release my records to:** **Yellowhawk Tribal Health Center**
Attention: Medical Records
46314 Timíne Way
Pendleton, OR 97801
Phone: 541.966.9830 | Fax: 541.240.8751

By Patient:

_____ _____ Date: _____
(Print name) (Signature)

Or By Patient's Representative:

_____ _____ Date: _____
(Print name and describe authority) (Signature)