Sacred Circle Healthcare
Health Division of CTGR

**OFFICE USE ONLY**
**Patient Eligibility Status:**

| | |
|---|---|
| Direct/Tribal | ☐ |
| Direct/Other Indian | ☐ |
| Direct/Tribal Descendant | ☐ |
| Direct Other Descendant | ☐ |

| Chart # |
|---|
| |
| **Tribe** |
| |
| **Tribal Quantum** |
| |

**Official Signature:** _____ Date: _____

# Purchased Referred Care (PRC) Registration Application

## Part 1: PATIENT INFORMATION

| | | |
|---|---|---|
| **PATIENT LEGAL NAME (Last, First Middle)** | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** |
| **BIRTH SEX** ❑ Male ❑ Female ❑ Other / **GENDER IDENTITY** | **CITY OF BIRTH -- STATE OF BIRTH** | |
| **MOTHER'S MAIDEN NAME (Last, First)** | **MOTHER'S PLACE OF BIRTH (City -- State)** | |
| **FATHER'S NAME (Last, First)** | **FATHER'S PLACE OF BIRTH (City -- State)** | |
| **HOME PHONE** / **CELL PHONE** | **EMAIL** | |
| **Consent to SMS or Email PRC Notifications** ❑ Opt Out of ALL SMS or Email ❑ Authorize SMS and Email ❑ Authorize SMS Only | | |
| **HOME ADDRESS (Street Name, Apt/Unit Number, City, State, Zip Code)** | **MAILING ADDRESS (Street Name, Apt/Unit Number, City, State, Zip Code)** | |
| **MARITAL STATUS (Check One)** ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed | **ARE YOU A COLLEGE STUDENT** ❑ Yes Full-Time ❑ Yes Part-Time ❑ No | |
| **WORK STATUS** ❑ Full-Time ❑ Part-Time ❑ Self-Employed ❑ Unemployed ❑ Retired | **EMPLOYER** | |
| **FOR PATIENTS UNDER 18 – NAME OF PARENT/LEGAL GUARDIAN COMPLETING THIS FORM** | | |
| **FULL NAME (Last, First Middle)** | **RELATIONSHIP TO PATIENT** | |

## Part 2: TRIBAL INFORMATION

| | |
|---|---|
| **Is the Patient a Member of a Federally Recognized Tribe?** ❑ Yes ❑ No<br>**TRIBE INFORMATION (Name):** | **TRIBAL BLOOD QUANTUM** |

## Part 3: INSURANCE INFORMATION (Alternate Resource Screening)

| | | | |
|---|---|---|---|
| **MEDICAID** | **Have you applied for Medicaid Recently?** ❑ Yes ❑ No | **Are you eligible for Medicaid?** ❑ Yes ❑ No | |
| | **Date of Eligibility:** | **Date of Denial:** | |
| | **Recipient ID Number (Case Number):** | | |
| **MEDICARE** | **Are you over the age of 65?** ❑ Yes ❑ No | **Do you have Medicare?** ❑ No ❑ Yes, Part A ❑ Yes, Part B ❑ Yes, Part A & B | |
| | **Medicare Number:** | **Suffix:** | |
| | **Effective Date:** | | |
| **PRIMARY INSURANCE** | **Are you covered by another insurance?** ❑ Yes ❑ No | ❑ Medical ❑ Dental ❑ Vision ❑ Prescription | |
| | **Insurance Name:** / **Policy Number** | **Group Number** | |
| | **Policy Holder (Last, First Name)** | **Policy Holder Date of Birth** | |
| | **Policy Holder Address (Street, City, State, Zip)** | | |

| Part 3 Continued: INSURANCE INFORMATION (Alternate Resource Screening) | | | |
|---|---|---|---|
| **SECONDARY INSURANCE** | **Are you covered by another insurance?** ❑ **Yes** ❑ **No** | ❑ **Medical** ❑ **Dental** ❑ **Vision** ❑ **Prescription** | |
| | **Insurance Name:** | **Policy Number** | **Group Number** |
| | **Policy Holder (Last, First Name)** | | **Policy Holder Date of Birth** |
| | **Policy Holder Address (Street, City, State, Zip)** | | |

| Part 4: IN CASE OF EMERGENCY | | |
|---|---|---|
| **EMERGENCY CONTACT** | **CONTACT NUMBER** | **RELATIONSHIP TO APPLICANT** |
| | | |

## Part 5: CERTIFICATION

**I certify that the information that I have provided to Sacred Circle Healthcare is complete and accurate. I understand that if any information should change, it is my responsibility to provide Sacred Circle Healthcare PRC staff with ALL updated information (insurance card, verification of vision, dental and health coverage, name change, address change, or any other qualifying life changes).**

**I understand that if Sacred Circle Healthcare makes unnecessary or improper payments on my behalf based on the information that I provided, I may be liable for such payments, and I may be ineligible for Sacred Circle Healthcare Purchased Referred Care in the future.**

**I assign to Sacred Circle Healthcare any medical, dental, vision, substance use recovery, and/or behavioral health benefits that I am entitled to under the terms of my health care coverage, in whole or in part, for the services paid for or provided by Sacred Circle Healthcare. I authorize the release of the medical information necessary to process my submitted claim. Sacred Circle Healthcare shall maintain compliance with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). I agree to release my personal identifiable health information for the Confederated Tribes of the Goshute Reservation (CTGR) Sacred Circle Healthcare PRC Program.**

| SIGNATURE OF APPLICANT or PARENT/LEGAL GUARDIAN | DATE |
|---|---|
| | |