

DENTAL/CONTRACT HEALTH CARE/PURCHASED / REFERRED CARE APPLICATION 2015**-PLEASE PRINT LEGIBLY-
ENROLLEE INFORMATION**

Name:					Sex: M F		Tribal Roll #	
Date of Birth:			SSN:			Primary Phone:		
Marital Status: (circle one)		Married	Single	Divorced	Other	Cell Phone:		
Mailing Address:						Birth:	City	State
City:			State:		County:		ZIP Code:	
Are you a Veteran?		Y	N	Are You Registered at a VA Facility?		Y	N	If Yes, Where?
Father's Name _____ Place of Birth _____ Tribe: Cow Creek Other _____					Mother's Maiden Name: _____ Place of Birth _____ Tribe: Cow Creek Other _____			

EMPLOYMENT/INSURANCE INFORMATION (PLEASE SEND COPY OF FRONT & BACK OF INS. CARDS)

Current Employer:					
Employer Address:					
Spouse Name:			Spouse Employer:		
Spouse Employer Address:					
Are you a Full Time Student?			College or University:		
INSURANCE COMPANY		POLICY NUMBER	DATE ELIGIBLE	TYPE OF COVERAGE	NAME OF POLICY HOLDER/POLICY HOLDERS NAME AND DATE OF BIRTH
Medicare A or AB (Please circle)					
Medicaid – Oregon Health Plan					
Nesika				M D V RX	
Other Insurance:				M D V RX	
M-MEDICAL D- DENTAL V- VISION RX-PHARMACY				M D V RX	

CHILDREN/DEPENDENTS/MEMBERS OF YOUR HOUSEHOLD

Name	Relationship	Cow Creek		Insurance Coverage		Birth Date	FT Student?		Social Security Number
		Y	N	Y	N		Y	N	

MUST ATTACH IF NO INSURANCE: OHP proof or Current paystub showing you make too much money to qualify for OHP.

I certify the above information to be accurate and true to the best of my knowledge and authorize CCH&W to verify the accuracy of this application.

Applicant/Guardian Signature_____
Date**PLEASE READ AND COMPLETE BACK OF FORM**

I authorize the following people to discuss and/or receive information with Contract Health Services on my behalf. (The person receiving the information must be 18 years of age or older):

Name	Relationship and Phone number

Designated Legal Representative/Guardian

If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following.

Legal representative (print full name): _____

Legal relationship to individual: _____

Signature: _____ Date: _____

PRIVACY ACT OF 1974 (the "Act")STATEMENT FOR MAINTENANCE OF HEALTH RECORDS

Indian Health Service (Cow Creek Contract Health) 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. To those officers and employees of Indian Health Service (Cow Creek Contract Health) who have a need for the record in the performance of their duties;
2. As required under section 552 of the Act;
3. For a routine use as defined in subsection (a)(7) of Section 522a of the Act and described under subsection (e)(4)(D) of Section 522a of the Act;
4. To the Bureau of the Census for purposes of planning or carrying out a census or survey or related activity pursuant to the provisions of title 13;
5. To a recipient who has provided Indian Health Service (Cow Creek Contract Health) with advance adequate written assurance that the record will be used solely as a statistical research or reporting record, and the record is to be transferred in a form that is not individually identifiable;
6. To the National Archives and Records Administration as a record which has sufficient historical or other value to warrant its continued preservation by the United States Government, or for evaluation by the Archivist of the United States or the designee of the Archivist to determine whether the record has such value;
7. To another agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of the agency or instrumentality has made a written request to the agency which maintains the record specifying the particular portion desired and the law enforcement activity for which the record is sought;
8. To a person pursuant to a showing of compelling circumstances affecting the health or safety of an individual if upon such disclosure notification is transmitted to the last known address of such individual;
9. To either House of Congress, or, to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee;
10. To the Comptroller General, or any of his authorized representatives, in the course of the performance of the duties of the Government Accountability Office;
11. Pursuant to the order of a court of competent jurisdiction; or
12. To a consumer reporting agency in accordance with section 3711(e) of title 31.

By signing below, you give your permission for the following I authorize Cow Creek Health & Wellness center, Contract Health Service, to release medical information required by my insurance company, other alternate resource or referring physician, to establish eligibility or to coordinate and/or negotiate payments on my behalf.

Applicant/Guardian

Date