INITIAL BENEFITS COORDINATION CONSULTATION

Name: Age: D.O.B.: PHONE NUMBER:
Do you have any form of health insurance? ☐ YES ☐ NO If yes, please list: _____
IS MEDICAID ACTIVE? ☐ NO ☐ YES - ID#:

I , understand that Contract Health is the payer of last resort and I will comply with all recommendations fill and submit all necessary documentation. Please note, most all of these programs require you to do an update every year and I will always notify Contract Health of any changes within 10 days of the change. I UNDERSTAND FAILURE TO DO THIS WILL RESULT IN SUSPENSION OF BENEFITS.

Client Signature: _____ Date: _____

STOP IF YOU HAVE INSURANCE, ATTACH COPY OF IT ALONG WITH ID'S RESIDENCY REQUIREMENTS AND PLEASE GO TO PAGE 3
CONTINUE BELOW IF YOU DON'T HAVE ANY FORM OF INSURANCE.

Are you blind or disabled? ☐ YES ☐ NO **Are you pregnant or is someone in your household?** ☐ YES ☐ NO

HOW MANY MINOR CHILDREN ARE IN YOUR HOUSEHOLD?

***All Adults and Children without insurance must apply for Medicaid/MI CHILD/Healthcare.gov.**
****Please attach confirmation#/Approval/denial/pending status to this application.**

Confirmation # that you applied alternative medical coverage for Medical Coverage

☐ APPROVED ☐ DENIED ☐ PENDING

Do you have alternative healthcare options? ☐ YES ☐ NO

Please explain_____

NPS ID#: _____ HRN #: _____

FOR OFFICE USE ONLY

MAGI LEVEL: ☐ Above ☐ Below @ _____%

NOTES:_____
INCOME _____ FAMILY SIZE_____

CALLED:_____

VOICEMAIL: _____

I determined that the above client should be referred to all of the following services. It is possible this individual or family may qualify for the following services, based on the information provided on previous page.

☐ CONTRACT HEALTH ☐ BCBSM ☐ MI Child/Healthy Kids ☐ OTHER_____

☐ MEDICARE ☐ REGULAR MEDICAID ☐ HEALTHY MICHIGAN

☐ SSA OFFICE ☐ MSP/Extra Help ☐ HEALTHCARE.GOV ☐MICHIGAN.GOV/MIBRIDGES

Interviewer:_____ Date:_____

The Grand Traverse Band of Ottawa and Chippewa Indians
Contract Health Department
2605 N. West Bay Shore Drive • Peshawbestown, MI 49682 •
(231) 534-7884

THE INFORMATION BELOW IS REQUIRED TO COMPLETE THE APPLICATION PROCESS.

WE NEED THE FOLLOWING DOCUMENTATION:

☒ **COPY OF YOUR DRIVER'S LICENSE OR MICHIGAN STATE ID**

☒ **PROOF OF RESIDENCY (SEE SECOND PAGE FOR ACCEPTABLE DOCUMENTS)**

☒ **PROOF OF MEDICAID APPROVAL/DENIAL AND OR CONFIRMATION NUMBER IF THERE IS NO INSURANCE COVERAGE**

☒ **COPY OF YOUR TRIBAL ID**

☒ ALL MINOR CHILD APPLICATIONS MUST INCLUDE AN UPDATED COPY OF THEIR TRIBAL ID **AND** A COPY OF THEIR MINOR TRUST FUND STATEMENT **OR** A COPY OF THEIR REPORT CARD

COUNTY OF RESIDENCE: ☐ GRAND TRAVERSE ☐ CHARLEVOIX ☐ LEELANAU ☐ BENZIE ☐ MANISTEE ☐ ANTRIM

****THE PROTOCOL FOR SATISFYING THE "GOOD FAITH EFFORT TO SEEK AN ALTERNATE RESOURCE" WHEN THE APPLICANT HAS NO INSURANCE COVERAGE IS AS FOLLOWS: YOU HAVE 30 DAYS *TO SUMBIT AN APPROVAL OR DENIAL OR YOU WILL BE SUSPENDED AND INELIGIBLE FOR CHS SERVICES.*****

1. CONTACT YOUR LOCAL D.H.S. (DEPARTMENT OF HUMAN SERVICES) OR THE GTB BENEFITS ADMINISTRATOR ANGELINA RAPHAEL TO GET HELP WITH THE APPLICATION FOR STATE OR LOCAL HEALTH ASSISTANCE.

2. FILL OUT THE APPLICATION AT WWW.MICHIGAN.GOV/MIBRIDGES OR WWW.HEALTHCARE.GOV PRINT CONFIRMATION # WITH THE DATE AND TIME OF THE SUBMITTED APPLICATION.

3. FORWARD THE COPY VIA EMAIL ANGELINA.RAPHAEL@GTBIDIANS.COM PRINT/WRITE CONFIRMATION # AND WE CAN PRINT IT FOR YOU.

4. **YOU WILL NEED TO FOLLOW UP WITH DEPARTMENT OF HUMAN SERVICES TO GET YOUR INSURANCE IF YOU QUALIFY. IF YOU ARE DENIED FROM OVER INCOME I WILL HELP YOU GET EXEMPTION FOR YOUR 2014 TAXES.**

5. COMPLETE THE CHS APPLICATION WITH COPIES OF ALL REQUIRED DOCUMENTATION.

6. ***WHEN CONTRACT HEALTH REQUIREMENTS ARE MET YOU WILL RECEIVE YOUR CONTRACT HEALTH CARD AND SIGN THE CHS AUTHORIZATION FORM.*** YOU WILL BE REQUIRED TO APPLY AT LEAST ONCE A YEAR FOR CHS AND/FOR THE ALTERNATIVE RESOURCE.

TRIBAL COUNCIL RESOLUTION NO. 08-26.1904
ACCEPTABLE DOCUMENTATION

A COPY OF A VALID DRIVER'S LICENSE WITH THE PHYSICAL ADDRESS LISTED ON THE APPLICATION **AND ONE OF THE FOLLOWING:**

- A CURRENT UTILITY BILL;
- A CURRENT BILL THAT YOU RECEIVE ON A MONTHLY BASIS;
- MOST RECENT YEAR FORM W-2
- MOST RECENT YEAR FEDERAL INCOME TAX RETURN;
- MICHIGAN VOTER'S REGISTRATION CARD;
- CURRENT MONTHLY BANK STATEMENT

BILLS, STATEMENTS AND DOCUMENTS LISTED ABOVE MUST CONTAIN THE RESIDENT TRIBAL MEMBER'S NAME, PHYSICAL ADDRESS. UTILITY BILLS, MONTHLY BILLS AND BANK STATEMENTS MUST BE FOR THE MOST RECENT BILLING CYCLE AND NO OLDER THAN 30 DAYS FROM THE DATE OF APPLICATION FOR ENROLLMENT.
ONLINE STATEMENTS OR BILLS ARE NOT ACCEPTABLE DOCUMENTATION FOR ADDRESS VERIFICATION

ALTERNATIVE OPTION #1

A COPY OF YOUR PHOTO TRIBAL ID, **AND TWO OF THE FOLLOWING:**

- A CURRENT UTILITY BILL;
- A CURRENT BILL THAT YOU RECEIVE ON A MONTHLY BASIS;
- MOST RECENT YEAR FORM W-2
- MOST RECENT YEAR FEDERAL INCOME TAX RETURN;
- MICHIGAN VOTER'S REGISTRATION CARD;
- CURRENT MONTHLY BANK STATEMENT

BILLS, STATEMENTS AND DOCUMENTS LISTED ABOVE MUST CONTAIN THE RESIDENT TRIBAL MEMBER'S NAME, PHYSICAL ADDRESS. UTILITY BILLS, MONTHLY BILLS AND BANK STATEMENTS MUST BE FOR THE MOST RECENT BILLING CYCLE AND NO OLDER THAN 30 DAYS FROM THE DATE OF APPLICATION FOR ENROLLMENT.
ONLINE STATEMENTS OR BILLS ARE NOT ACCEPTABLE DOCUMENTATION FOR ADDRESS VERIFICATION

ALTERNATIVE #2

A COPY OF YOUR VALID DRIVER'S LICENSE, MICHIGAN ID, OR PHOTO TRIBAL ID, **FILL OUT AN AFFIDAVIT FOR CERTIFICATION OF RESIDENCY FOR CO-HABITANTS RESIDENT TRIBAL MEMBER.**
AFFIDAVITS ARE AVAILABLE IN EACH DEPARTMENT

MINORS
PLEASE TURN IN A COPY OF THE MINOR'S TRUST FUND BANK STATEMENT, A BILL, OR A COPY OF SCHOOL RECORDS.
BILLS, STATEMENTS AND DOCUMENTS LISTED ABOVE MUST CONTAIN THE RESIDENT TRIBAL MEMBER'S NAME, PHYSICAL ADDRESS. UTILITY BILLS, MONTHLY BILLS AND BANK STATEMENTS MUST BE FOR THE MOST RECENT BILLING CYCLE AND NO OLDER THAN 30 DAYS FROM THE DATE OF APPLICATION FOR ENROLLMENT.

GTB Contract Health Services Application
Group: GTB

Grand Traverse Band of Ottawa and Chippewa Indians
2605 N. West Bay Shore Drive
Peshawbestown, MI 49682
(231) 534-7884

Section 1 Head of Household Information

Effective Date:

Last Name: First Name: Middle:

Social Security Number: Date of Birth: Tribal Enrollment #:

Physical Address: City: State: Zip:

Phone Number: Sex: Male ☐ Female ☐

Mailing Address: City: State: Zip: OR: **Same As Above** ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Date of Marriage: Date of Divorce:

Is anyone in the household pregnant? Yes ☐ No ☐ If yes, name: Due Date:

Section 2 Family Household Information

Spouse/Dependent Name	Relationship	Date of Birth	Tribe/Enroll # (if applicable)	Sex	Social Security	Address (if different from above)	Current Insurance

Section 3 Insurance Information

Self/Spouse/ Dependent Name	Current Insurance Coverage	Insurance Numbers	Effective Dates	Medical	Dental	Vision	Prescription Drugs

I certify that all statements are true and complete to the best of my knowledge. I authorize any physician, medical facility, employer, having information as to employment, medical coverage, or medical care, for my spouse, dependent children and myself to give such information to GTB Contract Health or its administrators to determine eligibility for coverage. GTB Contract Health is a payer of last resort. I agree that the company may release such information to its representatives or re-insurers or as permitted by law. I also understand that if I or any members listed on this application use the GTB Family Health Clinic we may also be eligible for services under the Medical Relief Block Grant.

***Signature of Tribal Member: _____ Date: _____

For Office Use Only:
Approved Signature _____ Date: _____ Processed: _____

AUTHORIZATION TO DISCUSS MEDICAL SERVICES WITH DESIGNATED PERSONS

I, (APPLICANT) _____ AUTHORIZE THE RELEASE OF INFORMATION REGARDING MY HEALTHCARE AND BILLING TO THE **GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS CONTRACT HEALTH SERVICES PROGRAM**.

GTB CHS Staff: Stella Chippewa, Jackie Bressette, Mary Jo McSauby, Angelina Raphael
NAME(S)

2605 N. West Bay Shore Dr. Peshawbestown, MI 49682
ADDRESS (IF DIFFERENT)

231-534-7884
PHONE NUMBER

MY SIGNATURE PROVES THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND EXPLAINED TO ME IN A LANGUAGE THAT I UNDERSTAND. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT WILL EXPIRE 1 (ONE) YEAR FROM THE DATE SIGNED OR IMMEDIATELY UPON RECEIPT OF WRITTEN REQUEST TO REVOKE.

APPLICANT'S SIGNATURE: _____ DATE: _____

VERIFICATION OF RECEIPT OF CONTRACT HEALTH INFORMATION

_____ I HAVE RECEIVED THE CONTRACT HEALTH SERVICES (CHS) INFORMATION. I WILL REVIEW IT AND
INITIALS IF I HAVE ANY QUESTIONS I WILL CONTACT MY CONTRACT HEALTH SPECIALIST.

VERIFICATION OF YEARLY UPDATE & CHANGE IN CONTACT INFORMATION

_____ I UNDERSTAND THAT MY CHS FILE **MUST** BE UPDATED ONCE A YEAR DURING THE MONTH SEPTEMBER.I ALSO UNDERSTAND THAT FAILURE
INITIALS TO UPDATE AND REPORT ANY CHANGES IN MY ADDRESS, NAME, PHONE NUMBER / CONTACT INFORMATION, OR MEDICAL COVERAGE(S) COULD RESULT IN SUSPENSION OF MY BENEFITS THROUGH GTB CONTRACT HEALTH SERVICES.

WITH MY INITIALS ABOVE AND MY SIGNATURE BELOW I AGREE THAT I HAVE RECEIVED THE CONTRACT HEALTH INFORMATION. I ALSO KNOW THAT I **MUST** UPDATE MY FILE ONCE EVERY YEAR DURING THE MONTH OF SEPTEMBER.

APPLICANT'S SIGNATURE: _____ DATE: _____

CONTRACT HEALTH SERVICES (CHS)
AUTHORIZATION INFORMATION

You must obtain authorization from CHS at least **2 days/48 hours before your scheduled appointment**. Any appointments called into CHS the day of will result in you either rescheduling or be responsible for any charge incurred on that day.

X-rays and Lab Work will be same day approval.

Authorization for Emergency Room/Urgent Care Visit:
*****Notify CHS within 3 days/72 hours of onset of illness/accident.
*****Elders & persons with disabilities have up to 30 days to notify CHS of illness/accident.
*****When needing to go to Urgent care you are to use the MCHC Urgent Care at 550 Munson Ave in Traverse City. Only use the Main Munson Medical Center for Emergency life threatening situations.
If on weekend or after hours you can call Jackie Bressette work cell phone 231-360-7195.

CONTRACT HEALTH SERVICES APPOINTMENT HOTLINE—231-534-7223
Use this number to call in any appointments you have, or will have. Appointments must be called in 48 hours in advance. The hotline is checked daily for the processing of authorizations for eligible CHS clients.

Authorization for Prescriptions:
Must use the following Pharmacies:
Bayshore Pharmacy 231-271-6111
MCHC Pharmacy 231.935.8730

- **NPS Prescription Card Recipients –** these individuals **do not** need to notify CHS of any prescription refills. Please use your card at the pharmacy.
- **New CHS Clients –** will be able to get prescription the next business day after signing up for CHS unless you need to get prescription the same day. **EMERGENCY ONLY**!

CHS Priority Levels of Care
CHS payment is limited by priorities. Priority Levels of Care are posted at the clinic, CHS office and GTB Government buildings. Therefore, some treatments and procedures may be deferred based on levels of funding. CHS is not an entitlement program and cannot guarantee payment.

For any CHS questions you may have, please do not hesitate to call one of us below:

Stella Chippewa, CHS Claims Specialist	231-534-7931
Mary Jo McSauby, CHS Customer Service	231-534-7884
Patricia Mashka-Burfield, CHS Eligibility Specialist	231-534-7210
Angelina Raphael, Benefits/CHS Intake Coordinator	231-534-7731

Client Print Name: _____

Client Signature: _____ Date: _____

CHS Staff Signature_____ Date_____

Cc:file HRN #_____