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? ☐ YES ☐ NO - ID#_____

I _____, understand that Purchased/Referred Care 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 Purchased/Referred Care 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.

Name of Employer:_____ Hourly Wage:_____ AVG HOURS PER WK:_____

Are you 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_____

PRC Member ID:_____ Effective Date: _____ FY_____ 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.

☐ PURCHASED/REFERRED CARE ☐ BCBSM ☐ OTHER_____

☐ MEDICARE ☐ MEDICAID /HEALTHY MICHIGAN/ MI Child ☐ FEDERAL EXEMPTION

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

Interviewer:_____ Date:_____

The Grand Traverse Band of Ottawa and Chippewa Indians
Purchased/Referred Care
2605 N. West Bay Shore Drive • Peshawbestown, MI 49682 •
(231) 534-7884 or (231) 534-7210

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 PRINT CONFIRMATION # WITH THE DATE AND TIME OF THE SUBMITTED APPLICATION.

3. FORWARD THE COPY VIA EMAIL PRC@GTB-NSN.GOV 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 PRC APPLICATION WITH COPIES OF ALL REQUIRED DOCUMENTATION.

6. ***WHEN PURCHASED REFERRED CARE REQUIREMENTS ARE MET YOU WILL RECEIVE YOUR PURCHASED REFERRED CARE CARD AND SIGN PRC 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 Purchased/Referred Care Application

Grand Traverse Band of Ottawa and Chippewa Indians
2605 N. West Bay Shore Drive
Peshawbestown, MI 49682

Section 1 PRIMARY TRIBAL MEMBER INFORMATION

Last Name _____ First Name _____Middle_____

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

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip_____ Phone Number:_____ Sex: Male _____ Female _____

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

Section 2 Tribal Member's Family Information

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

Section 3 Insurance Information

Name of Tribal Members	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 Purchased/Referred Care or its administrators to determine Eligibility for coverage. GTB Purchased Referred Care 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 _____

AUTHORIZATION TO DISCUSS MEDICAL SERVICES WITH DESIGNATED PERSONS

I, (APPLICANT) _____HEREBY AUTHORIZE THE RELEASE OF INFORMATION REGARDING MY HEALTHCARE AND BILLING TO THE **GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS PURCHASED/REFERRED CARE**.

GTB PRC Staff: PRC@GTB-NSN.GOV
NAME(S)
2605 N. West Bay Shore Dr. Peshawbestown, MI 49682
ADDRESS (IF DIFFERENT)
231-534-7223-PRC HOTLINE
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 PURCHASED/REFERRED CARE INFORMATION

_____ I HAVE RECEIVED THE PURCHASED/REFERRED CARE (PRC) INFORMATION. I WILL REVIEW IT AND
INITIALS IF I HAVE ANY QUESTIONS I WILL CONTACT THE PURCHASED/REFERRED CARE ELIGIBILTY SPECIALIST.

VERIFICATION OF YEARLY UPDATE & CHANGE IN CONTACT INFORMATION

_____ I UNDERSTAND THAT MY PRC FILE **MUST** BE UPDATED ONCE A YEAR DURING THE MONTH OCTOBER. 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 PURCHASE/REFERRED CARE.

WITH MY INITIALS ABOVE AND MY SIGNATURE BELOW I AGREE THAT I HAVE RECEIVED THE PURCHASED/REFERRED CARE INFORMATION. I ALSO KNOW THAT I **MUST** UPDATE MY FILE ONCE EVERY YEAR DURING THE MONTH OF OCTOBER.

APPLICANT'S SIGNATURE:_____DATE:_____

PURCHASED/REFERRED CARE (PRC)
AUTHORIZATION INFORMATION

You must obtain authorization from PRC at least **2 days/48 hours before your scheduled appointment**. Any appointments called into PRC 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 PRC within 3 days/72 hours of onset of illness/accident.
*****Elders & persons with disabilities have up to 30 days to notify PRC of illness/accident.
Only use the Main Munson Medical Center for Emergency life threatening situations.

PURCHASED/REFERRED CARE 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 PRC clients.

Authorization for Prescriptions:
Must use the following Pharmacies:
GTB Pharmacy 231-534-7350

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- **New PRC Clients –** will be able to get prescription the next business day after signing up for PRC unless you need to get prescription the same day. **EMERGENCY ONLY**!

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

For any PRC questions you may have, please do not hesitate to email or call: PRC@GTB-NSN.GOV or the PRC HOTLINE 231-534-7223

Client Print Name_____ Client Signature:_____ Date:_____

PRC Staff Signature_____ Date_____

Cc:file