

CIRCLE OF HEALTH APPLICATION

Attached you will find the Circle of Health application, to determine your eligibility for applying for a Private Health Plan which Circle of Health will pay the premiums.

All Circle of Health applicants are to apply before acquiring a Private Health Plan. This process begins with your Claims Processor, if you qualify you will then work with the Benefit Coordinator. You will need the following:

1. Income Verification – Copies of full check stubs, etc for entire household
2. Copies of all insurance cards, if any for entire household.
3. Student status is needed if anyone is attending college or vocational school.
4. Completed application.
5. Copy of Tribal ID enrollment card.

It is extremely important to submit the above listed documentation so that your eligibility can be determined.

Once the application is complete you can bring it directly to our office, fax it to (320) 676-8235 (make sure our office gets the original), or bring to the clinic on Monday 10am-2pm at the Eye Clinic Office. Your application will be reviewed within 24 hours, please contact your claims processor the following business day.

Circle of Health Application
Mille Lacs Band Health & Human Services
2605 Chiminising Drive
Isle, MN 56342
1-800-491-6106 or 320-676-8214

CONFIDENTIAL INFORMATION

Band Member Name _____ Telephone _____

Spouse / Maiden Name _____ Enrollment # _____

Social Security # _____ D.O.B. _____

List all individuals covered by your primary insurance policy (self, spouse, child).

Name	Relationship	Date of Birth	Social Security Number

Income Information Note: You must submit proof of all income you are claiming

Household Member Name	Earned Income	Unearned Income	Source of Income (see below)

Total Monthly Income for Household: _____

- Typical Sources of Income:
- Full-time Salary/Wages
 - Part-time Salary/Wages
 - Per Capita/Bonus
 - SSI
 - Social Security
 - Alimony
 - Commission
 - Child Support
 - Retirement/Pensions
 - Self-Employment
 - TANF
 - Veterans Benefits
- Percent disabled through VA __ %

Please explain any unique situation about your income here:

If applicant or any household member receiving TANF, please verify that you have not already been signed up for Medical Assistance or submit the information under MEDICAL INSURANCE.

If you have lost Minnesota health Care Program coverage what date: _____

Which county: _____ How long was the insurance active: _____

Reason for termination: _____

Is applicant or any household member, who is 25 or under, attending a post secondary or technical college?

Name _____ School Name/Address _____

MEDICAL INSURANCE

Does applicant or any household member have any medical coverage? YES NO

Please include MA, Medicare, Medicaid, Private Insurance, i.e., Blue Cross/Blue Shield, Medica, CCStpa, etc.

Company Name/Address _____

Is this family or single coverage? _____ If family coverage, please list who is covered? _____

If you have Medicare / Medicaid, please list the number _____

Effective Date _____

DENTAL INSURANCE

Does applicant or any household member have dental insurance? YES NO

Company Name/Address _____

Is this family or single coverage? _____ If family coverage, please list who is covered? _____

Effective Date _____

Did you remember to include?
~ Income Verification
~ Copies of Insurance Cards
This is important in determining your eligibility.

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AUTHORIZATION AND RELEASE

Name _____ Date of Birth _____
Address _____ Social Security # _____

The undersigned hereby knowingly and voluntarily authorizes Circle of Health:

1. To obtain and disclose information necessary to determine eligibility for private or state programs
2. To discuss information regarding my accounts with service providers, including but not limited to hospitals, clinics, collection agencies, and financial institutions;
3. To obtain and disclose information to third parties when necessary to satisfy *alternate resource requirements.

I hereby authorize persons or entities, which possess or maintain information about me to disclose that information to Mille Lacs Band of Ojibwe for the purposes set forth above.

THIS IS NOT A CONSENT TO DISCLOSURE OF MEDICAL RECORDS

A copy of this authorization shall have the same force, effect and validity as the original.

This authorization and release shall be valid from the date below, up to one (1) year. (If the authorization and release also relate to minor children of the originator, it shall be valid until the 18th birthday of each of the named children.)

Signature _____ Date _____

Parent / Guardian of children named below:

_____	_____	_____
Name	DOB	SSN
_____	_____	_____
Name	DOB	SSN
_____	_____	_____
Name	DOB	SSN
_____	_____	_____
Name	DOB	SSN

For office use only: use Minnesota Health Care Programs – Income and Assets Limits

Eligible yes ___ no ___ if no reason: _____

Must apply with County office and provide denial before Circle of Health will pay premium

Completed by: _____ Date: _____ Referred to Benefit Coor Date: _____