MILLE LACS BAND OF OJIBWE INDIANS

HEALTH AND HUMAN SERVICES REGISTRATION

ALL INFORMATION REQUESTED IS REQUIRED

2026

Health and Human Services Registration

- Please update information with the clinic if there are any changes to address, phone number, insurance coverage, etc.
- Any patient who DOES NOT have current health coverage will be referred to Circle of Health to be assisted to apply for coverage.
- All Tribal patients must have complete eligibility documentation on file to qualify for Purchased and Referred Care.
- If you have health records from another facility that are critical to the care you receive here, you must sign an authorization to release medical records to our facility.

FOR CIRCLE OF HEALTH ENROLLMENT (MILLE LACS BAND TRIBAL MEMBERS ONLY)

- You must complete and submit a new enrollment form annually, or each time you elect new health insurance coverage, or experience a change in family size.
- COH is a Mille Lacs Band of Ojibwe Tribal Member Program; your insurance premiums will be paid or reimbursed once all documentation is received or on file.
- COH Policyholder Notice: It is your responsibility to report any changes regarding your insurance coverage; this includes changes in employment as it relates to new employer eligibility or COBRA. Failure to report these events and changes to Circle of Health may result in a HOLD status on your benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for tribal benefits will be ineligible for Circle of Health benefits &/or Purchased and Referred Care.

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

18562 Minobimaadizi Loop, Onamia, MN 56359

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Name _____ **Suffix** _____ **SS#** _____
Last Name **First Name** **Middle Initial**

DOB _____ **Sex** ☐ M ☐ F **Birth Place** _____

Marital Status _____ **Race** _____ **Primary Language** _____

Tribe _____ **Enrollment #** _____

Address _____ **Homeless?** ☐
Street **City** **State** **Zip**

Phone _____ **County of Residence** _____

Phone _____ **Reminder Method** ☐ Phone ☐ Email ☐ Mail

Email _____ **Internet Access** ☐Home ☐School ☐Cell Phone ☐Work

Mother _____ **Birth Place** _____

Father _____ **Birth Place** _____

Legal Guardian/ Emergency _____ **Relation** _____

Address _____ **Phone** _____

Veteran ☐ Yes ☐ No **Dates of Service** _____ - _____ **Service Branch** _____

VA Card ☐ Yes ☐ No **VA Disability** ☐ Yes ☐ No **Service Connected** ☐ Yes ☐ No

Employer _____ **Employed** ☐ Full Time ☐ Part Time

RCV'D		RCV'D	
	TRIBAL ID OR CERTIFICATE OF ENROLLMENTS FOR ALL		NAME CHANGE DOCUMENTATION
	COPIES OF HEALTH INSURANCE CARDS		MARRIAGE CERTIFICATE
	BIRTH CERTIFICATES FOR MINORS		PROOF OF STUDENT STATUS FOR DESCENDANTS OVER 18
	SS #'S FOR ALL		GUARDIANSHIP (IF IT APPLIES)

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MILLE LACS BAND OF OJIBWE INDIANS

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Insurance Coverage: (Please check all that apply for your household)

☐ **I DO NOT HAVE ACTIVE HEALTH INSURANCE** *(CONTINUE TO PG 3)*

☐ **Medicaid (MA)** ☐ **MN Care** **Medicare:** ☐ Part A ☐ Part B ☐ Part D **Employer:** ☐ Medical ☐ Dental

POLICYHOLDER Carrier(s)

Policy Number Group

List all individuals covered by your primary insurance policy

Name	Relationship to Policyholder (self, spouse, child/other)	Date of Birth	Social Security Number
	Policyholder		

Copy of Insurance Coverage MUST BE Attached

Tribal Member and Descendant Verification Documents Needed:

1. Birth certificates for all 1st generation descendants 2. Tribal ID Card or Certificate of Enrollment

List all individuals who are tribal members or descendants

Name	MLB Descendant or MLB Enrolled Member	Enrollment #	Name of Enrolled Parent
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		
	☐ Enrolled ☐ Desc		

Consent for Treatment and Assignment of Benefits (AOB*)

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ALL INFORMATION REQUESTED IS REQUIRED

CONSENT FOR ROUTINE DIAGNOSTIC PROCEDURE AND MEDICAL TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) Ne Ia Shing Clinic, East Lake Clinic or Aazhamoog Clinic. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I acknowledge that no guarantees have been made to me for treatments or examination at Ne Ia Shing Clinic, East Lake Clinic, or Aazhamoog Clinic.

I understand the Tribal Health and Human Services (HHS), Circle of Health (COH), and Purchased/Referred Care (PRC) has a right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. Further, I understand that HHS may bring a claim or cause of action against the third party for recovery of each medical expense.
Therefore, I agree as follows:

1. To assign to the HHS/PRC/COH any claim of cause of action against the third person to the extent of the medical expenses paid, or any portion thereof.
2. To furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given and concerning any action instituted or to be instituted by or against a third party.
3. To notify the HHS/PRC/COH of a settlement with, or an offer of settlement from a third person and
4. To cooperate in the prosecution of all claims and actions by HHS/PRC/COH against such third person.

I authorize HHS/ PRC/ COH to furnish information to insurance carriers, and other third party payers' concerning my medical care and treatment to process claims in accordance with HIPAA health information standards. I assign all payments to be paid directly to HHS/PRC/COH for medical services rendered to me or my dependents. Confidentiality of records including information related to diagnosis of mental health, substance abuse, HIV/AIDS, and sexually transmitted disease are maintained per regulatory standards. This AOB authorization is in effect for one year, or if there is a change in health insurance coverage.

RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICE

I acknowledge that I have received/reviewed or have been offered the opportunity to receive a copy of the Notice of Privacy Practices for this facility. I certify that the above information provided to be accurate and true to the best of my knowledge and authorize HHS/PRC/COH to verify the accuracy of this application.

Print Name _____

Signature _____Date: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

MILLE LACS BAND OF OJIBWE INDIANS

HEALTH AND HUMAN SERVICES

RELEASE OF CONFIDENTIAL INFORMATION

Client Information	Name:_____ DOB:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____
I Authorize	Agency/Name: Circle of Health Phone:_____ Address:_____ Fax: 320-532-4354 State: MN Zip: 56359 Email:_____
To Do the Following: □ Release to □ Receive from	Agency/Name:_____ Phone:_____ Address:_____ Fax:_____ State:_____ Zip:_____ Email:_____
Information to be Released (What do you want sent or released?)	Dates of Service from:_____to:_____ (1 year if no dates are entered.) ■Tribal Enrollment Records □~~Educational Records~~ □~~Criminal History~~ □~~Probation Orders~~ □~~Court Records and Summaries~~ □~~Financial Records~~ □~~Personnel Records~~ □~~Payroll Records~~ □~~Band Assembly Records~~ □Oral Communication □Other_____
Purpose of Release (Why is it needed?)	The purpose of this release is for coordination of care, or: □Personal Use/Review ■Coordination of Services □Collateral Information ■Determine Eligibility □Litigation/legal □Other:_____
Method of Communication (How would you like your information communicated/send?)	Electronic Methods: □Standard email (PDF) □Secure email (PDF) Standard Methods: □Phone/Email Conversation □Fax □Mail □Pick up
Initial Action (What would you like done with the release?)	◉ Keep On File — For Future Use ○ Send Records — To Agency/Name Listed Above ○ Request Records — From Agency/Name Listed Above NOTE: If nothing is checked, release will be placed on file for future requests.

I understand I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. The information released in response to this authorization may be re-disclosed to other parties. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires. *Fees may be charged in accordance with MN Statute 144.92 and Federal Rule 45 C.F.R. 164.524. Mille Lacs Band of Ojibwe will not condition services dependent on whether this Release of Information is signed or not.

Client Signature:_____ Date:_____

Or Legally Authorized Representative Signature:_____ Date:_____

Representative's Relationship to the Client:_____