2020-2021
BOIS FORTE HEALTH AND HUMAN SERVICES
PURCHASED REFERRED CARE APPLICATION

☐ NEW ☐ RENEWAL

Office Use Only		
Date Received	**Chart Number**	**Face to Face Completed/Cards Printed By:** PRC Initials:

1. Name and address (please submit copy of valid driver's license, State of MN ID, tribal ID or 1854 ID card for all applicants)

First Name	MI	Last Name	D.O.B.	Sex M F	Marital Status
Street Address		City	State	Zip	County
Mailing Address (if different)		City	State	Zip	County
Social Security #		Home Phone		Other Phone:	

Applicant Tribal Enrollment: **Bois Forte** or Other: _____ Enrollment #: _____

Email Address: _____

Which Clinic do you prefer as your home clinic: Nett Lake Vermilion

2. Others living with you or others you are applying for (please provide ID or birth certificates for any child without IDs)
(list your spouse, parents/guardians of children under 21, stepparents, children and stepchildren living in your home.)

Name	SS#	Relation to you	Sex	Marital Status	Date of Birth	Is Person Applying?	Is Person Enrolled?
			M F			Yes No	Yes No
			M F			Yes No	Yes No
			M F			Yes No	Yes No
			M F			Yes No	Yes No

If there are additional family members please list them on the back of this form.

Have you lived at this address for the past 30 days? Yes No

YOUR APPLICATION IS NOT CONSIDERED COMPLETE UNTIL YOU SUBMIT ALL REQUIRED DOCUMENTATION (ID, BIRTH CERTIFICATE FOR CHILDREN UNDER 18, INSURANCE CARD INFORMATION, & YOUR COMPLETED APPLICATION) **and IF YOU ARE NEW TO PRC PROGRAM, A FACE TO FACE INTERVIEW WITH YOUR PRC CASE MANAGER IS NEEDED**. **You will have 30 days to submit all required verification**.

3. Did anyone have health insurance this month or does anyone expect to have health insurance next month? No- Please see Patient Benefits Case Manager Yes - Please Submit copy of all medical cards

4. Is anyone living away from home for a short time? No Yes-fill in below					
First Name MI Last Name			Social Security #	Date of Birth	Relationship to you
Are you applying for this person? No Yes	Date left	Date Expected to Return	Reason for not living at home		

5. By signing below, I hereby agree to use Bois Forte or Vermilion as my family's primary clinic.

Your Signature: _____ **Date:** _____

Please provide copies of the following for your file for all applicants:

***Current Medical and Dental Insurance Cards**
***Tribal ID, 1854 Treaty ID or valid Driver's license/State of MN ID**
***Marriage License (if recently married)**
***Divorce Decree (if recently divorced)**
***Birth Certificates for children with no ID card**

If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

Your Signature	Date
Signature of Authorized Representative	Date

Please mail, email or submit your application in person to your preferred location :

Destinie Villebrun
Patient Benefits Case Manager-Nett Lake
Nett Lake Clinic
5219 Lakeshore Drive
Nett Lake, MN 55772 **Phone: (218) 757-3650**
Destinie.villebrun@boisforte-nsn.gov

Kristal Strong
Patient Benefits Case Manager-Vermilion
Vermilion Clinic
1613 Farm Road South
Tower, MN 55790 **Phone: (218) 753-2182**
Kristal.strong@boisforte-nsn.gov

BOIS FORTE PURCHASED/REFERRED CARE

Nett Lake Clinic
PHONE: (218) 757-3650

Vermilion Clinic
Phone: (218) 753-2182

AUTHORIZATION AND RELEASE

Name: _____ **DOB:** _____

Address: _____ **SSN:** _____

_____

The undersigned hereby knowingly and voluntarily authorize the Bois Forte Purchased/Referred Care

1. To obtain and disclose information necessary to determine eligibility for services from or through the Bois Forte Purchased/Referred Care Program (PRC);
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 and entities, which possess or maintain information about me to disclose that information to Bois Forte Purchased/Referred Care 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 fore, effect and validity as the original.

This authorization and release shall be valid from the date below, up to one (1) year.

Signature: _____ **Date:** _____

Parent/Guardian of children below:

Name _____ DOB: _____ SSN: _____

Name _____ DOB: _____ SSN: _____

Name _____ DOB: _____ SSN: _____

Name _____ DOB: _____ SSN: _____