DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Oklahoma City Area Indian Health Service
Purchased/Referred Care, Ste. 143, 701 Market Drive
Oklahoma City, OK 73114

Dear Patient,

Due to COVID-19, the PRC program is temporarily eliminating face-to-face contact. Therefore, the Oklahoma City Area Indian Health Service (IHS) has modified how patients may provide necessary documentation to us. Please use the IHS secure data transfer email system, mail, or fax information in lieu of providing it in person.

We have received a referral for you but are unable to address because your eligibility has not been established. Establishing eligibility is essential to processing the referral and determining payment approval or denial. In order to establish eligibility, complete and provide the following items within 15 business days from receipt of this letter. If an extension is needed, please call us.

1. Complete pages 2-4 of this packet,
2. Provide copies of Social Security Card, Front and Back of Insurance Card(s), Proof of Indian Descent or Certificate Degree of Indian Blood, and one of the following, which shows your name/that you live within the PRC delivery area:

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing name and address.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
Valid U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
	Property Deed	

3. If you are unable to provide one of the items above, please fill out the last 3 pages of this packet.
4. Return all items listed in 1, 2 and/or 3, to PRC by either:
   a. IHS secure email system (call (405) 951-6075 for assistance from PRC),
   b. mail to the address above (upper right header),
   c. or fax items to (405) 951-3920.

Our office is available for questions at (405) 951-6075, Monday through Friday from 8 am until 4 pm. Please contact us anytime we can be of assistance.

Thank you,

Taveah George, MPA
Director, Purchased/Referred Care
Oklahoma City Area Indian Health Service

SHAWNEE SERVICE UNIT NEW CHART APPLICATION

Please complete one New Chart Application for every new patient.
Present this completed form along with certified documentation copies in order to establish a new patient chart.

Legal Name: _____ Alias/Maiden: _____

DOB: _____ City of Birth: _____ State of Birth: _____

SSN: _____ Sex: ☐ M ☐ F Race: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

Religious Preference: _____ Primary Language: _____ Preferred Language: _____

Physical Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date Moved To This Address: _____

IF APPLICATION IS FOR A MINOR, PLEASE USE APPLICANT EMPLOYER FOR MOTHER AND SPOUSE EMPLOYER FOR FATHER.

Applicant Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

☐ Fulltime ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Military

Spouse Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

☐ Fulltime ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Military

Number in Household: _____ Total Household Income: $_____*-Per?* ☐ Week ☐ Month ☐ Year

Emergency Contact: _____

Relationship to Applicant: _____ Phone #: _____

Emergency Contact Address: _____ State: _____ Zip: _____

Name of Mother: _____ Maiden: _____

Mother's City of Birth: _____ Mother's State of Birth: _____

Name of Father: _____

Father's City of Birth: _____ Father's State of Birth: _____

Next of Kin: _____

Relationship to Applicant: _____ Phone #: _____

Kin's Address: _____

City: _____ State: _____ Zip: _____

Tribal Affiliation: _____ Tribal Blood Quantum: _____

Total Indian Blood Quantum: _____

Are You a Veteran? ☐ Yes ☐ No If Yes, What Branch? _____

Date of Entry: _____ Date of Discharge: _____

Do You Have a Valid VA Card? ☐ Yes ☐ No Vietnam Service Connected? ☐ Yes ☐ No

Service Connected Disability? ☐ Yes ☐ No Describe VA Disability: _____

Do You Have Private Insurance? ☐ Yes ☐ No Do You Have State Medicaid? ☐ Yes ☐ No

Do You Have Medicare? ☐ Yes ☐ No Do You Have Retirement Railroad Coverage? ☐ Yes ☐ No

Include the policy holder name and policy holders date of birth:_____

If you have insurance please provide copy of front and back of each card or present for scanning

Do you have an active claim pending for an: Accident? ☐ Yes ☐ No

Injury? ☐ Yes ☐ No

Workman's Comp? ☐ Yes ☐ No

Crime? ☐ Yes ☐ No

If **YES** please provide the date, location, description of what happened and who was involved: _____

_____

_____

_____

_____

Was the incident reported to the Police or other authorities? ☐ Yes ☐ No

Were the other parties injured? ☐ Yes ☐ No Are Attorneys involved? ☐ Yes ☐ No

I understand that after verifying eligibility and applying for a new chart, an electronic health record may be created within the Shawnee Service Unit. I certify that the above information is true to the best of my knowledge and that no information provided is deliberately falsified.

Signature of Patient or Parent/Legal Guardian of Minor **Date**

Registration Staff Use Only:
Reviewed and Approved by: _____

Shawnee Service Unit

Acknowledgment of Receipt of IHS Notice of Privacy Practices

I hereby acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices at the following Shawnee Service Unit facility:

_____
Name of Patient

_____ _____
Signature of Patient Date

If patient is unable to sign:

_____
Name of Legal Representative and state relationship to patient

_____ _____
Signature of Patient Representative Date

_____ _____
Signature Of Registration Staff Date

Staff Only: For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the IHS Notice of Practices because:

_____

_____ _____
Signature of Registration Staff Date

Registration Staff Use Only:
Reviewed and Approved by: _____ D.O.B. _____

DEPARTMENT OF HEALTH AND HUMAN SERVICE
Indian Health Service

FORM APPROVED: OMB NO. 0917-0040
Expiration Date: 03/31/2022
See OMB Statement on Page 3

PURCHASED / REFERRED CARE PROOF OF RESIDENCY

The Indian Health Service (IHS) provides services through Purchased/Referred Care (PRC) to American Indian/Alaska Native people who live within the designated geographic area known as a PRC delivery area. The PRC program is authorized to pay for medical care provided to IHS beneficiaries by non-IHS or Tribal, public or private health care providers, depending on the availability of funds.

Federal law generally requires residency within the PRC delivery area in order to receive services through PRC. If you are requesting PRC authorization of payment by the IHS for medical services/treatment from a non-IHS provider, you must prove that you reside within the PRC delivery area.

Please print when completing this form. If you need help in completing the sections, you may ask for assistance and instructions from the IHS PRC Office.

Section A: Your Information (Required)

Last Name	First Name	Middle Initial	Date of Birth

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?

Home street address:	Post Office Box:	Home phone number:

City:	State:	Zip Code:	Cell phone number:

Physical location: *(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)*

Have you lived at this location for more than six months? ☐ Yes ☐ No	If not, provide your old address.
Are you homeless? ☐ Yes ☐ No	Contact phone number:

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to beneficiaries of the IHS who live in the PRC delivery area.

Applicant Signature _____ Date _____

Provide one of the following to show that you live within the PRC delivery area.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing address and withholding taxes.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
Valid college ID with a photo	Property Deed	Marriage License
Other Tribal government issued documents.		

If you do not have any of these documents, you can prove that you live in the PRC delivery area by completing Section B **or** Section C.

Another resident of the PRC delivery area, who knows where you live, can verify your residency by filling out Section B. If you do not know anyone who is willing or able to verify where you live, a local non-profit social services provider can verify your residency by completing Section C.

Section B: Individual Verifier's Information

This section must be filled out by a resident who knows where you, the applicant, live – someone you live with is best. If you do not know anyone who is willing or able to verify where you live, a local non-profit organization that provides you with services may complete Section C for you. *(You do not need to fill in Section C if this section is completed.)*

Last Name:	First Name:	Middle Initial

Home address:	Post Office Box:	Home phone number:

City:	State:	Zip Code:	Cell phone number:

Physical location: *(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)*

How do you know the applicant?

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to people who live in the PRC delivery area.

By signing below, I verify that, to the best of my knowledge, the applicant listed in Section A on page 1 lives at the location stated in Section A.

Verifier's Signature _____ Date _____

The individual verifier must sign Section B and provide a copy of at least one (1) of the following documents showing the **verifier's** name and address.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing name and address.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
Valid U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
	Property Deed	

Section C: Organizational Verifier's Information

This section must be filled out by a local non-profit organization, social services, or other services organization that serves you, the applicant. *(You do not need to fill in Section B if this section is completed.)*

Organization Name:	Organization Tax Exempt ID Number:	
Verifier's Name:	Verifier's Title:	
Telephone number:	Email address:	
Organization Address:		
City:	State:	Zip Code:

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to people who live in the PRC delivery area.

By signing below, I verify that, to the best of my knowledge, the applicant listed in Section A on page 1 lives at the location stated in Section A.

Verifier's Signature _____ Date _____

Reminder to the Applicant:

Before you turn in this application, make sure it is complete. **In order to be completed, you must have:**

- Section A filled out with documentation; **OR**
- Section A filled out with no documentation **AND** completed Section B or Section C.
- If you use Section B, you must have a copy of the individual verifier's proof of residency documentation.

Privacy Act Notice

The Privacy Act of 1974 (5 U.S.C. § 552a (e) (3) requires that the following notice be provided to you. The information requested on the Purchase/Referred Care (PRC) Proof of Residency form is collected to determine eligibility for and administration of PRC benefits under the Snyder Act (25 U.S.C. § 13), the Transfer Act of 1954 and implementing regulations at 42 C.F.R. Part 136. Purposes and uses – the information requested is collected for the purposes of reviewing eligibility for PRC services. The information provided on this form will be maintained in the applicant's medical record. The information will not be disclosed to entities outside the Indian Health Service (IHS) without prior written permission except for routine uses identified in the IHS System of Records 09-17- 0001 Medical, Health and Billing Records. Effects of nondisclosure – the information is required in order to determine eligibility for the receipt of PRC services.

OMB Burden Statement

Public reporting burden for this collection of information is estimated to average 3 minutes per response including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, Office of Management Services, Division of Regulatory Affairs, 5600 Fishers Lane, Mail Stop 09E70, Rockville MD 20857, RE: OMB No. 0917-0040. Please DO NOT SEND this form to this address.

Instructions for Completing IHS Form 810 -- AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE.
5. Section IV, check the appropriate box as applicable.
   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.
   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.
   c. **Other *(specify)*** -- e.g., Purchased Referred Care (PRC), Billing, Employee Health.
   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
6. Section V, if a different *expiration* date is desired, specify a new date. For HIE, a date 5 years in the future is recommended in order to provide health information for continuity of care.
7. Section V, Please sign (or mark) and date.

OKLAHOMA CITY AREA OFFICE
INDIAN HEALTH SERVICES
PURCHASED REFERRED CARE
701 MARKET DRIVE STE 143 OKLAHOMA CITY, OK 73114
PHONE: (405) 951-6075 FAX: (405) 951-3920
HOURS: 8AM-4PM MONDAY – FRIDAY

Taveah George, Director of PRC	(405) 951-3723
Jan Robb, Health System Specialist	(405) 951-3933
Randi Schoeppel, RN Case Manager	(405) 951-3828

SHAWNEE PRC TECHNICIANS:

*Sommer	*Kathy	*Linda
*Tashina	*Sharon	*Beverly
	*Dax	*Kathy Sue

AFFORDABLE CARE ACT INFORMATION:

APPLICATION – www.healthcare.gov
Call (800) 318-2596 24 hours a day, 7 days a week (TTY: (855) 889-4325)
www.tribalhealthcare.org
National Indian Health & Outreach Education (NIHOE) Health Care News & Materials
www.marketplace.cms.gov
Website with more information
www.healthcare.gov/tribal
Q&A about Marketplace

ALL EMERGENCY ROOM VISITS MUST BE REPORTED BY CALLING (405) 951-6075 WITHIN 72 HOURS OF YOUR ER CHECK-IN TIME.
PATIENTS 65 & OLDER HAVE 30 DAYS TO CALL PRC.