MACT Mariposa Amador Calaveras Tuolumne HEALTH BOARD INC

A Non-Profit Tribal Corporation

Rite of Passage Patient Registration

Instructions

Return completed forms[1] and supporting documentation to your local MACT Clinic or:

Mail: MACT Health Board, Inc.
Health Information Management
PO Box 939
Angels Camp, CA 95222

Fax: (209) 674-6200
Email: registration@macthealth.org[2]
Phone: (209) 754-6262

Registration forms and supporting documentation will be reviewed for completeness and processed in the order received. **Incomplete forms will not be processed and will delay your ability to establish care.** Once registration forms have been processed, you will be contacted to schedule your first appointment with each of the selected services in Section 2.

[1] For your convenience, this registration packet can be completed electronically by downloading the latest version of Adobe Acrobat Reader at https://get.adobe.com/reader/. Please note: MACT Health Board, Inc. does not endorse this product or Adobe Systems Incorporated.

[2] Information transmitted over the Internet may be at risk for loss of confidentiality. MACT Health Board, Inc. does not recommend sending confidential information, such as Social Security numbers over the Internet or via e-mail.

Services

Services for all Rite of Passage "ROP" patients will be provided at our San Andreas facility. Please select the services that are of interest. ☐ Behavioral Health ☐ Dental ☐ Medical ☐ Optometry

Standards of Behavior

MACT Health Board, Inc. "MACT" has a zero tolerance policy regarding the following:

- Public intoxication
- Drug or tobacco use on premises
- Violence
- Threats
- Weapons, of any kind
- Abusive language
- Inappropriate behavior
- Profanity
- Drug diversion
- Non-compliance with healthcare advice

I understand that any of the above mentioned actions and/or behaviors may result in my permanent dismissal from all MACT services and facilities. ____
Initial

Care, Custody, Control, and Conduct

Do any of the following apply? (Check all that apply. Additional supporting documentation required.)

☐ Adoption
☐ Caregiver
☐ Court Ordered Parental Rights
☐ Emancipated Minor
☐ Foster Care
☐ Group Home
☐ Guardian ad Litem
☐ Kinship Care
☐ Legal Guardian
☐ Legal Name Change
☐ Self-sufficient Minor
☐ Tribal Customary Adoption

Patient Information

Patient's Legal Name: _____ _____ _____
First Middle Last

Gender Identity: ☐ Male ☐ Female ☐ Other: _____ **Date of Birth**: _____

Social Security Number[1]: _____ **Primary Language**: _____

[1] Failure to provide a social security number (SSN) or individual taxpayer identification number (ITIN) may prevent your ability to establish care and/or continue to receive services at MACT Health Board, Inc.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Veteran Status**: ☐ Yes ☐ No

Physical Address: _____

City: _____ **State**: _____ **Zip**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____ **Employer**: _____

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

American Indian or Native Alaskan Eligibility

_____ _____ _____ _____
Tribe of Membership Roll Number Certificate of Indian Blood (CIB) State Where Enrolled

Race and Ethnicity

Please check one box that best describes your race or ethnicity.

☐ American Indian/Alaska Native
☐ Black or African American
☐ Hispanic or Latino[1]
☐ White
☐ Multiple Races[2]

Asian
☐ Multiple Asian[3]
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Indian
☐ Japanese
☐ Korean
☐ Laotian
☐ Other Asian
☐ Vietnamese

Pacific Islander
☐ Multiple Pacific Islander[4]
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Pacific Islander

[1] If you identify with Hispanic or Latino (alone or in combination with any other race)
[2] If you identify with more than one race that is not Hispanic or Latino, select Multiple Races.
[3] If you identify with more than one Asian ethnicity, select Multiple Asian.
[4] If you identify with more than one Pacific Islander ethnicity, select Multiple Pacific Islander.

Parent or Legal Guardian Information

Primary Parent or Guardian Name: _____

Gender Identity: ☐ Male ☐ Female ☐ Other: _____ **Date of Birth**: _____

Relationship to Patient:

☐ Parent ☐ County Case Worker ☐ Guardian ad Litem ☐ Other:
☐ Adoptive Parent ☐ Court-ordered Custodial Parent ☐ Legal Guardian _____
☐ Caregiver ☐ Foster Care Parent ☐ Social Worker

Social Security Number: _____ **Primary Language**: _____

Physical Address: _____

City: _____ **State**: _____ **Zip**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____ **Employer**: _____

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

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Secondary Parent or Guardian Name: _____

Gender Identity: ☐ Male ☐ Female ☐ Other: _____ **Date of Birth**: _____

Relationship to Patient:

☐ Parent ☐ County Case Worker ☐ Guardian ad Litem ☐ Other:
☐ Adoptive Parent ☐ Court-ordered Custodial Parent ☐ Legal Guardian _____
☐ Caregiver ☐ Foster Care Parent ☐ Social Worker

Social Security Number: _____ **Primary Language**: _____

Physical Address:_____

City: _____ **State**: _____ **Zip**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____ **Employer**:_____

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

Insurance Information

Do you have insurance? ☐ Yes ☐ No **Are you interested in our sliding fee scale?** ☐ Yes ☐ No

Medical Insurance

Primary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Secondary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Tertiary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Dental Insurance

Primary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Secondary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Vision Insurance

Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Insurance Card(s)

If you have insurance, MACT Health Board, Inc. requires a copy of the front and back of your insurance card(s) for insurance eligibility/verification purposes, as well as prescription drug-related matters. Please attach a copy of the **front and back** of your insurance card(s) with this packet. **If you are unable to provide a copy of your insurance card(s) with this registration packet, you must bring them to your first appointment.**

Prescription Drug Coverage

Do you have a separate insurance card for prescription drug coverage? ☐ Yes ☐ No

If yes, please attach a copy of the **front and back** of your insurance card(s) to this packet or bring them to your first appointment.

Financial Agreement

Financial Policy. MACT Health Board, Inc. "MACT" follows regulations and laws set by Indian Health Services and the State of California. Depending on your status, you will be financially responsible for all, part, or none of the services performed at any of our clinics, as well as any and all costs associated with the collection of services rendered. Proof of eligibility for Medicare, Medi-Cal, and contracted insurance companies is the responsibility of the patient. It is your responsibility to know your insurance plan, covered benefits, and co-pays and deductibles. MACT will submit insurance claims for patients whose insurance is provided by a health plan in which it contracts however; MACT expects same day payment for all co-payments, deductibles, and non-covered services. In cases where patients are required to pay cash for an appointment, a close approximation of the cost must be paid on the day services are rendered. If the actual cost of the treatment amount is different, the difference will be billed or refunded to the patient.

Authorization to Release Information and Assignment of Benefits. MACT has my permission to release information as needed for insurance processing and for my insurance to release payment to MACT Health Board, Inc.

Medicare Authorization: I agree that payment of authorized Medicare benefits be made on my behalf to MACT for any services provided. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I will be responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible amounts are based upon the charge determination of the Medicare carrier.

Emergency Contact Information

Emergency Contact's Name: _____ _____ _____
First Middle Last

Relationship to Patient: _____ **Phone Number**: _____

☐ I decline to provide an emergency contact

Pharmacy

MACT Health Board, Inc. "MACT" participates in the 340B Drug Pricing Program which may increase access and convenience to prescription drugs for our patients. Are you interested in changing your pharmacy to a pharmacy that has contracted with MACT for 340B pricing? ☐ Yes ☐ No

Preferred Pharmacy: _____

Phone: _____ **Fax**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Consent for Treatment

All non-emergency health care requires consent before treatment can be provided. When a patient is a minor, a parent or legal guardian usually must consent for that child's medical treatment. Placement into Rite of Passage does not automatically remove a parent or legal guardian's right to consent to health care.

Check all boxes that apply and provide supporting documentation, as necessary.

Court Order Is Required

☐ The patient has been declared a dependent child and the Juvenile Court has removed the parent or legal guardian's right to consent to medical treatment.

☐ The patient is in temporary custody. The county case worker may consent for necessary care and has notified the parent, guardian, or other person holding consent rights of her/his intent. The parent, guardian, or other person holding consent rights however; has objected and care cannot be provided without a court order authorizing treatment, unless it is an emergency.

- ☐ The court has granted the county case worker the right to consent to medical care on the patient's behalf.
- ☐ A separate court order which is different than a care, custody and control order, is required.
- ☐ The patient has been removed from her/his parents' custody and the child welfare agency has been given custody and control of the dependent child. A separate consent order is required and provided.

Court Order Is Not Required

☐ The patient is in temporary custody. The county case worker may consent for necessary care and has notified the parent, guardian, or other person holding consent rights of her/his intent. The parent, guardian, or other person holding consent rights has not objected and care can be provided without a court order authorizing treatment.

☐ Beyond ordinary care, the court has authorized a relative caregiver to provide the same legal consent for the minor's medical, surgical, and dental care as the custodial parent of a minor if, the child has been placed in a planned permanent living arrangement with that caregiver.

☐ The court has authorized treatment for the patient because a licensed physician has recommended treatment; notice has been provided to the patient's parent or guardian; and the juvenile court has found that no parent, guardian, or person standing in loco parentis is willing and able to provide consent. Certain special care requires a court order.

☐ The medical provider is unable to obtain consent in a timely manner and has decided to provide necessary emergency care without obtaining prior consent.

☐ This is an emergency situation that requires the patient to consent on her/his own behalf under federal or state law.

☐ This is an emergency situation. The county case worker may provide consent to necessary medical care and has made a reasonable attempt to notify the parent, guardian, or other person holding consent rights. No court order is required if this person objects.

Special (Sensitive) Services

Certain sensitive services require the consent of the patient while others may require a court order or court authorization.

Check all boxes that apply and provide supporting documentation, as necessary.

☐ The patient is a minor and may consent to certain types of health care on her/his own accord.

☐ The patient is a minor less than 12 years of age. A court order is required for the following services:

1. HIV/AIDS: Testing and Treatment

☐ The patient is a dependent minor that needs psychotropic medication and has been removed from parental custody. Only the court has the authority to consent to the administration of psychotropic medication and may only do so upon a physician's request. However, the court may delegate this authority back to the parent(s) if it finds that the parent(s) pose no danger to the patient and has the requisite capacity. Court authorization is required.

☐ This is an emergency situation that requires the administration of psychotropic medication without court authorization. For this purpose, an emergency situation occurs when:

1. A physician finds that the child requires psychotropic medication to treat a psychiatric disorder or illness; and
2. The purpose of the medication is:
    a. To protect the life of the child or others, or
    b. To prevent serious harm to the child or others, or
    c. To treat current or imminent substantial suffering; and
3. It is impractical to obtain authorization from the court before administering the psychotropic medication to the child.

☐ If medication is administered in an emergency, court authorization still must be sought as soon as possible but no later than two (2) court days after the emergency administration of the psychotropic medication.

Additional Required Documentation

In addition to the completion of this form, provide any of the following pertinent court documentation to MACT Health Board, Inc.

Check all boxes that apply and provide supporting documentation, as necessary.

If there is a court order related to California Welfare and Institutions Code Sections 366.24, 366.26, 727.3, and/or 727.31, provide:

☐ **Orders under Welfare and Institutions Code Sections 366.24, 366.26, 727.3, 727.31 (Form JV-320)**

If there is a court order related to California Welfare and Institutions Code Sections 361 et seq., provide:

☐ **Findings and Orders after Dispositional Hearing (Form JV-415)**

If there is a court order with an additional dispositional attachment related to California Welfare and Institutions Code Sections 361 and/or 361.2, provide:

☐ **Dispositional Attachment: Removal from Custodial Parent – Placement with Previously Noncustodial Parent (Form JV-420)**

☐ **Dispositional Attachment: Removal from Custodial Parent – Placement with Nonparent (Form JV-421)**

If the court has authorized psychotropic medication for a dependent, provide:

☐ **Order on Application for Psychotropic Medication (Form JV-223)**

The following forms which support Form JV-223 may also be provided but are not required:

☐ **Application for Psychotropic Medication (Form JV-220)**

☐ **Physician's Statement – Attachment (Form JV-220A) or**

☐ **Physician's Request to Continue Medication – Attachment (Form JV-220B)**

If the patient has been provided any of the following forms and any of these forms pertain to the care, custody, control, and/or conduct over the patient, provide all that apply:

☐ **Termination of Dependency (Juvenile) (Form JV-364)**

☐ **Termination of Juvenile Court Jurisdiction Non-minor (Form JV-365)**

☐ **Findings and Orders after Hearing to Consider Termination of Juvenile Court Jurisdiction Over a Non-minor (Form JV-367)**

☐ **Disposition – Juvenile Delinquency (Form JV-665)**

☐ **Custodial and Out-of-Home Placement Disposition Attachment (Form JV-667)**

If the parent is providing health insurance or has been court ordered to provide health insurance coverage for the patient, provide:

☐ **Application and Order for Health Insurance Coverage (Form FL-470)**

☐ **A copy of the patient's health insurance card**

If the parent has terminated her/his employment and/or benefits and is required to provide health insurance coverage for the patient, provide:

☐ **Termination of Benefits/Employment Notice (Form DCSS-0114)**

If the patient has received a Medi-Cal Benefits Identification Card (BIC), provide:

☐ **Medi-Cal Benefits Identification Card (BIC)**

Acknowledgements and Authorization

By signing this document, you certify that the information provided throughout this form is true and accurate. Additionally, you indicate receipt, understanding, and acceptance of the following MACT Health Board, Inc. forms and policies:

1. Appointment Cancellations and No-Shows
2. Financial Agreement
3. Notice of Privacy Practices
4. Standards of Behavior
5. **For Dental Patients**: Dental Board of California's Dental Materials Fact Sheet

Furthermore, you acknowledge and accept that MACT Health Board, Inc. employs and uses the services of **Non-Physician Medical Practitioners (NMPs)** such as Physicians Assistants and Nurse Practitioners. You may be treated by an NMP.

I/we certify that I/we have read and understand the above information to the best of my/our knowledge. The undersigned patient, and/or responsible party gives permission for MACT Health Board, Inc. to administer healthcare treatment and advice as necessary.

_____	_____	___/___/____	_____
Print Name of Patient	Signature of Patient[1]	MM DD YYYY	Relationship to Patient

_____	_____	___/___/____	_____
Print Name of Parent/Authorized Representative	Signature of Parent/Authorized Representative[2]	MM DD YYYY	Relationship to Patient

[1] The signature of the patient is only required if s/he is legally capable of consenting to her/his own care and/or treatment.

[2] If this form is completed and signed by a non-custodial parent, including but not limited to a legal guardian, person(s) having legal custody of the minor, or a caregiver of the child who is a relative of the child and who may authorize medical care and dental care under Section 6550 of the California Family Code, supporting legal documentation is required.

Further Instructions

Please return the following forms to MACT Health Board, Inc. as instructed in Section 1:

☐ Pages 1-9 of the Rite of Passage Patient Registration Packet and supporting documentation
☐ Health History Questionnaire
☐ **For Medicare Patients**: Medicare Secondary Payer Questionnaire
☐ Authorization for Use or Disclosure of Protected Health Information, optional
☐ Authorization for Third-Party Consent to Treatment of Minor Lacking Capacity to Consent, optional
☐ Permission to Verbally Discuss Protected Health Information, optional

Behavioral Health-Related Documentation

☐ Treatment summary letter with diagnosis, if possible/applicable
☐ Treatment plan, if possible/applicable
☐ Current or past medication contraindications, if possible/applicable
☐ Therapy summary, if possible/applicable