Ho-Chunk Nation Health Department
At-Large Health Management Program

APPLICATION COVER LETTER

TO: Ho-Chunk Nation At-Large Area Member

FROM: Natalie Bird
At-Large Health Patient Reg./Billing Manager

RE: At-Large Health Management Program

Enclosed are a blank At-Large Health Management Program (ALHMP) application and a release of information form to be completed and returned. To avoid any delays in the processing of your application a checklist is enclosed. Be sure to list all household income and members.

Approved applicants are required to notify the ALHMP of any changes made throughout the year. Failure to notify the ALHMP of any changes will result in the termination of your benefits and any bills incurred after termination date will be your responsibility to pay. You are required to update your application yearly or your benefits will terminate.

ALHMP is not intended to pay old bills or non-medical needs. It is not an entitlement program and is to be considered as a "payer of last resort." Applicants are required to apply for alternate resource(s) or their application will be denied. A letter of decision must be received in this office, before your application will be considered.

Whether your application is approved or denied, you will receive notice in the mail. If your application is approved, you are required to call and preauthorize your appointments. If no authorization was given, your claims will be denied and you will be responsible for unauthorized services.

Return your completed application and required information to the address shown below. If there are any questions or concerns, please don't hesitate to call.

NOTE: IF REQUIRED INFORMATION IS APPLICABLE BUT NOT INCLUDED, YOU WILL BE NOTIFIED BY MAIL AND YOUR APPLICATION WILL BE ON HOLD FOR 30 DAYS; IF AFTER 30 DAYS THIS INFORMATION IS NOT RECEIVED YOUR APPLICATION WILL BE DENIED. IF AFTER 30 DAYS OF SUBMITTING YOUR APPLICATION YOU HAVE NOT RECEIVED NOTICE TO THE STATUS OF YOUR APPLICATION PLEASE CONTACT THE ALHM PROGRAM AT 715-284-9851 EXT 35315. IF AT ANY TIME THE INFORMATION YOU SUBMIT IS FOUND TO BE UNTRUE, YOUR BENEFITS WILL TERMINATE AND ANY BILLS INCURRED AFTER THE TERMINATION DATE WILL BE YOUR RESPONSIBILITY TO PAY.

Ho-Chunk Health Care Center
P.O. Box 636 • N6520 Lumberjack Guy Road
Black River Falls, WI 54615
Phone (715) 284-9851 (Ext. 35315) • Fax (715) 284-0100

Ho-Chunk Nation Health Department
At-Large Health Management Program

ALHMP Intake Checklist

By submitting your supporting documents, you will eliminate having your application being placed on a **hold status**.

- ☐ Is your application complete for all items?
- ☐ If employed, you must apply for insurance through employer. If you don't qualify for insurance or no insurance is offered, please submit employer's written statement.
- ☐ If employed, and have no insurance or unemployed with no insurance, you must apply for the Bronze Plan under the Health Insurance Marketplace or in some states (listed below) to the Medicaid Expansion Program. This can be done by going to HealthCare.gov, contacting a Benefit Specialist or Navigator at an Indian Health Service Facility, or contacting your local county Social Services for assistance. Once this is complete, submit plan information to the address listed below.
- ☐ Submit a copy of your insurance card(s) front and back.
- ☐ Submit copies of all household income; per capita excluded.
- ☐ Submit copy of last year's tax returns (2023).
- ☐ Submit copies of Tribal ID's for all household members.
- ☐ Submit proof of address (i.e. D.L., State I.D., Utility Bill, or Rent Receipt).

Medicaid Expansion States: AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, MT, NC, NE, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, UT, VA, VT, WA, AND WV.

If you reside in one of the states listed above, your state has expanded their Medicaid Program. This means that free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For assistance in applying to the Medicaid Expansion Program, contact your local county Social Services or Indian Health Services to apply for the Medicaid Expansion Program.

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HO-CHUNK NATION
AT-LARGE HEALTH MANAGEMENT PROGRAM
P.O. Box 636, Black River Falls, WI 54615
Telephone: 888-424-3584 Ext 35315
Fax: 715-284-0100

APPLICATION
*** PLEASE PRINT CLEARLY ***

FOR OFFICE USE ONLY
Date Approved/Denied_____/_____
Approved_____Medical_____Rx_____Dental____Optical
Other_____

(APPLICANT) LAST NAME	FIRST NAME	MIDDLE	MAIDEN	Social Security #	Birth Date	Sex M F	Age

FATHER'S LAST NAME	FIRST	TRIBAL AFFILIATION	MOTHER'S MAIDEN NAME	FIRST	TRIBAL AFFILIATION

PHYSICAL ADDRESS City State Zip MAILING ADDRESS City State Zip

COUNTY	TELEPHONE #	ALTERNATE #	VETERAN? ◯YES ◯NO	EMPLOYED? ◯ YES ◯ NO
			TRIBAL ID#	DISABLED? ◯ YES ◯ NO

**** LIST SPOUSE & DEPENDENTS UNDER 18 IN YOUR HOUSEHOLD ****

Last Name	First	Middle	Sex	Birth Date	Age	Social Security #	Enrollment #

INCOME SOURCE	**HEAD**	**SPOUSE/OTHER**	**Annual Income**
Gross Pay ◯ Weekly ◯ Bi-weekly ◯ Monthly	$		$_____
Social Security / Supplemental Security Income / Disability	$		**Household size _____**
Per Capita / Unemployment / Workman's Comp / Other	$		**Poverty level_____%**

Do you have insurance or other coverage? ◯Yes ◯No(Name/Type)_____

Have you requested assistance from other resources,(i.e. Medical Assistance)? ◯Yes ◯No(Submit notice of decision)

Description of medical needs, including acute and/or chronic health problems: _____

I CERTIFY that the information on this application is true and complete. I understand that I may be asked to provide supportive documentation relative to this application and that providing false information may result in my being declared ineligible for assistance through the ALHM Program. I also understand that it is my responsibility to **NOTIFY THE AT-LARGE HEALTH MANAGEMENT PROGRAM OF ANY CHANGE IN THE ABOVE INFORMATION WITHIN 30 DAYS OR MY HEALTH BENEFITS WILL TERMINATE.**

I FURTHER AUTHORIZE and give my permission to the ALHM Program to disclose and seek confidential information in efforts to determine program eligibility for one year from my signature and date below. **YOU WILL RECEIVE A DETERMINATION NOTICE WITHIN 30 DAYS UPON RECEIPT OF YOUR APPLICATION. IF WITHIN 30 DAYS YOU DON'T RECEIVE NOTICE; PLEASE CONTACT US IMMEDIATELY.**

Applicant Signature:_____**Date:**_____

Parent or Legal Guardian Signature:_____**Date:** _____

HO-CHUNK NATION
AT-LARGE HEALTH MANAGEMENT PROGRAM

RELEASE OF INFORMATION

I hereby give authorization to the Ho-Chunk Nation At-Large Health Management Program to request medical records from any of my family's health care providers in order to determine the amount of coverage that will be provided for services. Furthermore, I give my written consent to the At-Large Health Management Program to disclose and/or obtain any and all confidential information which will assist the program coordinator in reaching a decision to either approve or deny my At-Large Health Management Program application. ***All information received will be confidential under the provision of the U.S. Department of Health and Human Services Privacy Act.***

PRINT HOUSEHOLD TRIBAL MEMBER(S) NAME(S)	**BIRTH DATE(S)**
• _____ (SELF)	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____

TRIBAL MEMBERS OVER 18 MUST SIGN RELEASE FORM

SIGNATURE _____DATE_____

SIGNATURE _____DATE_____