

Fitness Membership Reimbursement Program Application

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street Address City, State, Zip

Home Phone: _____ Cell Phone: _____

Email Address: _____ Tribal ID: _____

Facility using: _____ Reimbursement Amt. Requested _____

Spouse Name: _____ Tribal ID: _____

Child(ren): Name	Age	DOB	Sex	Tribally Enrolled	Tribal ID:
_____				Yes No	_____
_____				Yes No	_____
_____				Yes No	_____
_____				Yes No	_____
_____				Yes No	_____
_____				Yes No	_____

Terms of Reimbursement Agreement:

1. Applicant must be a Ho-Chunk enrolled tribal member. **Initials:**
2. Applications and all required documentation must be returned to the Health & Wellness staff at W9850 Airport Rd. Black River Falls, WI 54615. **Initials:**
3. Reimbursements will be paid out for 6 consecutive month memberships at a time. The participant is responsible for paying the initial six months to the facility directly. Upon completion of the six month membership the participant may complete the reimbursement fitness membership application with the Health & Wellness Division. **Initials:**
4. Participants must complete all necessary documents for reimbursement, including:
 - a. Application for fitness membership reimbursement.
 - b. Usage reports for the past 6 months from the facility for all family members on the account.
 - c. Receipt of 6-month payment receipt from facility (the amount requested for reimbursement).

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- d. Medical provider release from exercise if there is any reason the participant did not meet the required usage amounts for reimbursement. **Initials:**
5. To be eligible for a family membership the family members must be either a Ho-Chunk enrolled spouse or Ho-Chunk enrolled children or descendant under the age of 18. **Initials:**
6. The maximum reimbursement amounts per six months for memberships are as follows (These numbers are based on average membership costs for all areas):
- a. Family: maximum of \$800 per six months. **Initials:**
 - b. Single: maximum of \$400 per six months.
7. Co-pay breakdown in attached policy. Co-pay will be deducted from total approved reimbursement amount. **Initials:**
8. Applications and guidelines are subject to change at any time for any reason by the Health & Wellness staff. **Initials:**
9. Any incomplete (any missing information/paperwork) applications greater than 6 months old from the signature date will be shredded and considered expired. **Initials:**
10. Reimbursement requests must be made within one year of the purchase receipt date for memberships beginning January 1, 2020. **Initials:**
11. I have read, fully understand and accept the terms of the Fitness Membership Reimbursement Program Policy. **Initials:**

Signed:

Dated:

FOR OFFICE USE ONLY:

Submitted:

- 1. Application
- 2. Usage reports
- 3. Receipt for membership
- 4. Medical Release (if applicable)

Average usage:

Receipt Amount (Maximum \$400 single/\$800 family):

Co-pay deduction amount:

Reimbursement amount:

Approved by (initials):

Date:

Date of reimbursement processed: