INDIAN HEALTH BOARD
Quality Healthcare for Our Community

1315 East 24th Street
Minneapolis, MN 55404
Phone: (612) 721-9800
Fax: (612) 721-2904

Sliding Fee Discount / MNsure Intake Form

Legal Name (as it appears on ID) _____

Social Security Number _____ Date of Birth _____

Home Phone Number _____ Cell Phone Number_____

Do you have medical insurance and or Medical Assistance/Medicare? Y / N

Do you have dental insurance? Y / N

Please note: this form is for internal purpose only and will not be shared with any other agency.

Are you a US Citizen or US National? Y / N If No: US resident for over 5 years? Y / N

Please circle immigration status**:** LPR (Green Card) Visa/Passport Non-citizen/non-resident

Household size information (Household members or dependents include those persons living in the same home who are related by birth, marriage, registered domestic partnership, or adoption.) **If child is over 18 and not a full-time student, do not include.**

Name	DOB	Social Security Number **(if available)**	Relationship	Do they need insurance?

Household Income Information

Please list below **all** sources of income in your household, including yourself.

Name	Relationship	Source of Income	Amount Received	Frequency (weekly,biweekly,monthly)

If no income has been reported, please explain in the space provided how you pay for living expenses, such as food, housing, clothing, and other necessities.

I certify that the information provided is complete and accurate. I authorize Indian Heath Board of Minneapolis or any other State or federal agency to verify any of the above data and release the above information to referring/mutual providers of care. I agree to notify Indian Health Board of any changes in my family size or income. I understand that I must reapply for the sliding fee discount every 12 months.

_____ _____

Guarantor Signature Date

Waiver:

I certify that I have been given information about IHB's Sliding Fee Discount and MNsure and have chosen not to apply where eligible. I understand that I will not be eligible for any discount on IHB services and must pay my bill in full.

_____ _____

Guarantor Signature Date

IHB USE ONLY

Review by: _____ Family Size: _____

Discount Level: _____ Income: _____

Certification (Effective) Date: _____ Entered into computer by: _____

Date:_____