PURCHASED REFERRED CARE STUDENT HEALTH FORM

**Revised 11/2017

NOTE: PART A required of the student for IHS use in determining eligibility for payment of medical care through the Purchased Referred Care Prg

PART A: COMPLETED BY STUDENT

Semester ____________ Last Sem completed __________

( )New Student ( )Returning Student Enrolment status: (FULL TIME /PART TIME)

( ) Classes on campus ( ) Classes Online ( ) Training ______________

STUDENT NAME: ____ Date of Birth: ____________

Last First Mid Initial

Home Agency/Tribe: ______________ Census # __________ Social Security# ____________

Permanent Home Address: ____

Address while at school: ______________________________ Telephone: ____________

NAME OF SCHOOL: ____

School Address: ____

Telephone: ____

Educational Funding: **( )Zuni Educ. Scholarship ( )Job Placement & Training ( )Other/Ramah SETS**

What PHS Indian Health Facility have you received services from in the past? (I.e., ZPHS, GIMC, ASU, etc.)

______________________________ Last Visit: __________ Insurance: ______________

Please provide names of dependents who will accompany you while your in school: If no dependents, leave Blank

Name(s)	Relationship	Date of Birth	Tribe/Census #

PART B: IHS USE ONLY

I understand that **THIS IS NOT AN AUTHORIZATION FOR MEDICAL CARE.** I have received an Introduction to the IHS/PRC Program with a member of the PRC Staff and fully understand the rules and regulations set forth and understand my responsibilities when seeking PRC services and that any false Information provided will result in denial of services.
I authorize the ZIHS/PRC staff to contact the school for enrollment verification, if necessary.

______________________________ ______________________________

Student Signature Date PRC Signature Date

CERTIFICATION

The above named student certifies he/she lives on or near the __________Indian Reservation. Verify if this individual lives on or near his/her Indian Reservation, in accordance with 42 CFR, Part 36, Contract Health Services.

( ) Lives on or near his/her Indian Reservation, in accordance with 42. CFR.
( ) Does not live on or near his/her Indian Reservation, in accordance with 42. CFR.

Name/Title of Certifying Official: ______________________________ Date: ____________________

IHS CEO or Administrative Officer

IHS Facility Address: **Zuni Indian Health Services POBx 467 Zuni, New Mexico 87327**

Telephone Number: **(505) 782-7346/7347/7348 FAX: (505) 782-7551**

PRC USE ONLY:

			Comments:
Spring__________	Full-Time	Part-Time	
Summer__________	Full-Time	Part-Time	
Fall__________	Full-Time	Part-Time	