The Saginaw Chippewa Indian Tribe Health Assistance Program Application

Member Services 7070 E Broadway St, Mt. Pleasant, MI 48858 1-800-884-6271

Braces Application

Personal Information

Full Name of Applicant		II, III, Jr. or Sr.
Mailing Address		City, State
Street Address	Zip Code	County
Phone Number	M00 #	Birth Date
Insurance Carrier	Name on Insurance Card	Policy Number

Braces Grant Amount Requested **$_____**	**CHECKLIST** ☐ **Completed and Signed Application**
Total $6500—$1800(Your copay) = $4700 **$4700— $ that your insurance paid = Amount of Grant**	☐ **Detailed Invoice (Showing Insurance)** ☐ **Proof of Co-Pay**
Failure to send in all necessary documentation will slow down your application. If you have any questions at all please call Member Services at 1-800-884-6271	**Make sure that the invoice or bill from the doctor or facility shows how much your insurance paid and that the bill is paid in full.**

I HEREBY CERTIFY THAT ALL INFORMATION IN THIS APPLICATION IS TRUE, CORRECT AND IS COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT GIVING FALSE OR INCOMPLETE INFORMATION CAN RESULT IN REFERRAL TO THE PROSECUTING ATTORNEY FOR FRAUD, AND/OR RECOVERY OF FUNDS PAID ON MY BEHALF AND/OR EXCLUSION FROM THE HEALTH ASSISTANCE PROGRAMS FOR A PERIOD OF ONE YEAR.

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION BY THE APPROPRIATE AGENCIES TO THE SAGINAW CHIPPEWA INDIAN TRIBE, MEMBER SERVICES FOR THE PURPOSE OF VERIFYING INFORMATION NEEDED TO ESTABLISH ELIGIBILITY FOR THE PROGRAM.

THE APPLICATION MUST BE COMPLETELY FILLED OUT. IF THE APPLICATION IS NOT COMPLETED, IT WILL BE RETURNED TO THE CLIENT WITH A MISSING INFORMATION LETTER THAT POINTS OUT THE INFORMATION NEEDED. THE CASE WILL BE CLOSED IF DOCUMENTATION IS NOT RETURNED WITHIN 60 WORKING DAYS FROM THE DATE ON THE MISSING INFORMATION LETTER.

THE MEMBER SERVICES WILL HAVE 14 WORKING DAYS TO PROCESS THE GRANT WHEN THE COMPLETED APPLICATION INFORMATION AND RECEIPTS HAVE BEEN RECEIVED BY THE MEMBER SERVICES PROGRAM.
WHEN THE PURCHASE ORDER IS FORWARDED TO THE ACCOUNTING DEPARTMENT, A MINIMUM OF 14 WORKING DAYS MUST BE ALLOWED FOR THE CHECK TO BE PROCESSED. ALL CALLS REGARDING THE APPLICATION, CHECK OR GRANT PROCESS ARE TO BE DIRECTED ONLY TO MEMBER SERVICES CASE MANAGER.

HEALTH ASSISTANCE PROGRAM RESERVES THE RIGHT TO REVIEW PAYMENT OF GRANT IF EXPLOITATION IS SUSPECTED.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY RESPONSIBILITY IN COMPLYING WITH THE ABOVE.

APPLICANT SIGNATURE:_____ DATE:_____