California Rural Indian Health Board

rev. 1/26/2016

CRIHB Options 2016

Client High-Level Screening and Eligibility Form

THP Staff Use Only

Section 1. Client Information

Last Name:	First Name:	MI

Date of Birth: MM/DD/YYYY	Last 4 digits of SSN:	Other Names Used:	Tribal Code/Affiliation:
____ /____ / _____	XXX-XX- ___ ___ ___ ___		

Section 2. Verification of IHS, Medi-Cal coverage, and Age

2a) IHS eligible? *(If YES, go to 2b. If NO, client does not qualify; go to 4a.)*	☐ YES	☐ NO
2b) Has Medi-Cal coverage *(If YES, go to 2c. If NO, client does not qualify; go to 4a.)*	☐ YES	☐ NO
2c) Between the ages of 21-64? *(If YES, go to 4b. If NO, client does not qualify; go to 4a.)*	☐ YES	☐ NO

Section 3. Limitations related to Medicare coverage

If client is less than 64 years of age and has Medicare coverage, a client would not be eligible for medical services (acupuncture, audiology, chiropractor, podiatry and speech therapy). However, client would qualify for dental services, which are not Medicare covered benefits.

Section 4. Program Eligibility Certification

4a) ☐ Not Eligible for CRIHB Options

4b) ☐ Eligible for CRIHB Options, complete Section 5 Use Group Code= CO or CCO

Section 5. Benefits ID number and Certification

If eligible, you must assign an 8 character benefit identification number as follows:

IHS Tribe Code: __ __ __ (Becomes the first 3 digits)

Last 4 digits of SSN: __ __ __ __ (The next 4 digits)

First Initial of Last Name: ___ (The last character)

This number becomes the client's benefit ID number: __ __ __ __ __ __ __ __

I certify the applicant meets the Indian Health Service eligibility requirement and is a Medi-Cal beneficiary.

X		/ /
Staff Signature	**Print Staff Name**	**Date**