Nimiipuu Health
Direct Contract Support Cost Settlement Fund
Assistance Application Form

Patient must provide:

- Nez Perce Tribal ID (Initial application only)
- Proof of Medical Appointment if requesting assistance for travel
- Proof of expense if requesting assistance for deferred medical services

Patient Name: _____ Tribal IDs: _____

Immediate Family Member Name: _____ DOB: _____

Address: _____

Phone Number: _____ Email: _____

Reason for Requesting Assistance: _____

If Requesting Travel Assistance:
Departure Date: _____ Return Date:_____

Name of Doctor/Medical Center: _____

Appointment Date: _____

By my signature below, I understand that the Direct Contract Support Cost Settlement Fund Policy has been explained to me and agree to the terms listed in the policy. I also understand that the assistance is designed to assist me, as the patient, in obtaining quality healthcare.

_____ _____
Signature Date

Submit complete application to:

Nimiipuu Health Finance Department
PO Box 367
111 Bever Grade Road
Lapwai, ID 83540

For questions or assistance, contact NMPH Finance Department at 208-843-2271 ext. 2811

For NMPH Staff use only:
Date Received: _____ Received by: _____
Prior Assistance Yes or No? If yes date and amount: _____
Eligible Yes or No? If No, Reason:_____
Referral Date: _____ Amount: _____