STANDING ROCK SIOUX TRIBE
COVID-19 VACCINATION INCENTIVE PROGRAM

Program Description:

The Standing Rock Sioux Tribe believes in the effectiveness and benefit of vaccinating against the COVID-19 virus and is encouraging all enrolled members of the Standing Rock Indian Reservation to obtain a vaccine. The CDC has found that COVID-19 vaccines are highly effective at preventing individuals from getting sick with COVID-19 and experiencing the most severe consequence of the disease, and may also prevent virus transmission to others. Consistent with CDC guidance to prevent the infection and spread of COVID-19 and as an integral part of its public health and safety measures, the Standing Rock Sioux Tribe strongly encourages all enrolled members who are eligible to receive a COVID-19 vaccine and can safely do so to get vaccinated against COVID-19. This includes the COVID-19 booster shot.

The American Rescue Plan Act of 2021, P.L. 117-2 (ARP Act), which was enacted in response to COVID-19 pandemic, provides funding to tribal governments to mitigate the fiscal effects from the COVID-19 public health emergency.

The Tribal Council developed the COVID-19 Vaccine Incentive Program as a general welfare program to respond directly to the COVID-19 public health emergency by providing an incentive to increase the number of tribal enrolled members who choose to get vaccinated and/or motivate enrolled tribal members to receive the Vaccine sooner than they otherwise would have, or to incentivize members to get the COVID-19 booster in accordance with CDC and FDA guidelines.

The CDC has promoted the benefits and safety of approved and Emergency Use Authorization approved COVID-19 vaccines. According to the CDC:

- COVID-19 vaccines currently approved or in development in the US do not contain the COVID-19 virus and will not make you sick with COVID-19.
- Getting the COVID-19 vaccine will not make you test positive for the COVID-19 virus.
- COVID-19 vaccinations have been shown to be highly effective at preventing you from getting sick with COVID-19 and experiencing the most severe consequence of the disease.
- COVID-19 vaccines may reduce the risk of spreading COVID-19.
- COVID-19 vaccines do not change your DNA.
- COVID-19 vaccinations are an important tool in helping to stop the pandemic.

For information about what you can expect when getting the vaccine, see the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html.

Vaccination Not a Substitute for Other COVID-19 Prevention Measures

This Voluntary Vaccination Program is a key part of our overall strategy and commitment to maintaining a safe and healthy community in light of the COVID-19 pandemic. This program is designed for use together with, and not as a substitute for, other COVID-19 prevention measures:

- Wearing face masks in all public places
- Social Distancing

- Temperature Check and Health Screening Protocols
- Cleaning and Sanitation

We need your full cooperation and compliance with this and other health and safety measures to make them effective and to protect our community by preventing the spread of COVID-19.

Eligibility:
Every Standing Rock Tribal enrolled member, over the age of 5 years old, who has received both of their shots of Moderna, Pfizer, or one shot of Johnson & Johnson, will be eligible to receive a one-time incentive of $2000.00. Tribal enrolled members who have previously received their vaccinations are eligible for this incentive.

If you have already received a vaccination incentive from another organization, you are eligible to receive the remaining balance up to $2000.00.

Process:
Legal guardians must complete the application and attach legal custody order for minor child, and proof of vaccination or complete the Authorization for use of Disclosure of Protected Health Information.

The emergency assistance is in compliance with the Indian general welfare assistance benefits in accordance with Tribal General Welfare Exclusion Act, Public Law 113-168, Internal Revenue Code Section 139E ("GWE"). The Standing Rock Tribal Council has determined that the vaccination incentives are reasonable and necessary and are considered general welfare payments. This incentive is a one-time, non-recurring payment.

Application Deadlines: You must SUBMIT this application with proof of vaccination (two doses) by June 30, 2022. This is a one-time only incentive.

The application is attached to this document and is available at the Tribal Administration Office or on the Tribe's website at www.standingrock.org. Completed applications, with necessary documentation (proof of enrollment, custody documentation, and vaccination) attached, should be delivered to the ARPA Office or the District office. When delivering your application to the Standing Rock Administration building, please indicate that you are dropping off your application. Keep a copy of your application for your records.

Payments for the Incentive will be processed through the tribe's regular accounts payable process. Payments may take two weeks or more, depending upon when the completed application, including proof of vaccination, was received by the Department. Checks for a minor child will be made in the name of the legal guardian.

Approved:
The Standing Rock Tribal Council has adopted Resolution #302-21 that authorizes this COVID-19 Community Vaccination Incentive Program and Application.

Acknowledgment of Receipt and Review

I, _____(name), acknowledge that on _____ (date), I received a copy of Standing Rock Sioux Tribe's Vaccination Incentive Program guidelines and that I have read it, understood it, and agree to comply with it. I understand that if I choose to get vaccinated, at the time of vaccination I will be provided with information from the vaccine administrator about the benefits and risks of the COVID-19 vaccine, and that signing this acknowledgment does not constitute consent to receiving the vaccine. I understand that the Standing Rock Sioux Tribe has the maximum discretion permitted by law to interpret, administer, change, modify, or delete these guidelines at any time with or without notice. Changes can only be made if approved by the Tribal Council.

The applicant acknowledges and understands that if any of the information contained herein which is material is false, is a misrepresentation, is intentionally incomplete, or inaccurate may result in denial of your application and or criminal prosecution per Standing Rock Sioux Tribe Code of Justice Title IV, Section 4-406(b) and Title III, Section 3-601.

_____
Signature

_____
Printed Name

_____
Date

Standing Rock Sioux Tribe
Vaccination Incentive Program Application

PLEASE PRINT CLEARLY AND LEGIBLY OR TYPE:

NAME:	
MAILING ADDRESS:	
EMAIL:	ENROLLMENT #:
PHONE:	DOB:
Report immediately any changes to your contact information	
VACCINE INCENTIVE RECEIVED FROM OTHER ORGANIZATION: **YES** **NO** AMOUNT: _____ The organization vaccine incentive received from is: _____	

Check one:		
_____ I received two doses of the Moderna vaccine	_____ I received two doses of the Pfizer vaccine	_____ I received 1 dose of the Johnson & Johnson vaccine

Dependents (5 – 17 years old) Checks for minor children will be issued to parent or legal guardian			
Name	DOB	Enrollment #	Vaccination Verified

I received all required doses of my vaccination at _____ and herby, authorize the Standing Rock Sioux Tribe Vaccination Incentive Program staff to contact the above named vaccination agency; I also consent for the above named vaccination agency to release medical information to Standing Rock Vaccination Incentive Department, in order to only verify that I have received full doses of my Covid-19 vaccination, for purposes of receiving the one-time Vaccination Incentive.

All tribal members must provide CDC COVID-19 Vaccination Record Card. If you do not have your vaccination card or immunization record, complete the Authorization for Use or Disclosure of Protected Health Information Form. All vaccine records will be verified prior to distribution of the eligible benefit.

I have read and agreed to the provisions as stated, any amounts paid based on fraudulent information will be recouped by the Tribe as per Standing Rock Sioux Tribe Code of Justice Title IV, Section 4-406(b) and Title III, Section 3-601.

_____ _____

Print Name Date

_____

Signature

Questions
Please contact 701-854-8680, Monday through Friday 8:00 a.m. – 4:30 p.m.
Email: SRSTARPA@standingrock.org Fax: 701-854-7299

FOR OFFICIAL USE ONLY	
Date Received:	Received by:
Vaccine Verified Date:	Verified by:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ (Name of Patient), hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY Standing Rock IHS	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS P O Box J	ADDRESS
CITY/STATE Fort Yates, ND 58538	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☒ Other *(Specify)* ARPA
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☒ Only information related to *(specify)* Vaccine Record

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION
ROI VERIFIED BY: _____
COMPLETE: _____
DRIVER'S LICENSE ID: _____
TRIBAL ID: _____
ID CARD: _____
OTHER: _____
HIM STAFF: _____
DATE: _____
PAGES: _____

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

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