



The Grand Traverse Band of Ottawa and Chippewa Indians

Behavioral Health Services

Intake Application

I. Client Information

Date of Application: _____ GTB Tribal ID: _____

Other Federally Recognized Tribe Name and ID: _____

Your Name: _____

Minor Child Name, if applicable: _____

Client Date of Birth: _____ Social Security Number: _____

Preferred Language: _____

Do you need an interpreter: Yes No If Yes, in what language? _____

Preferred Contact: E-Mail Home Phone Mobile Phone Mail Other: _____

Legal Address: _____

City _____ State _____ Zip _____

Mailing Address: _____

City _____ State _____ Zip _____

County of Residence: Grand Traverse Charlevoix Leelanau Benzie Manistee Antrim

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Gender: Female Male Prefer Not to Say Other: _____

Race:
 American Indian or Alaskan Native Asian
 White Native Hawaiian/Pacific Islander
 Black/African American Prefer Not to Say
 Hispanic Other

Tribe:
 Keweenaw Bay Bay Mills
 Little River Band Match-E-Be-Nash-She-Wish
 Saginaw Chippewa Little Traverse Band
 Hannahville Grand Traverse Band
 Lac Vieux Desert Other Federally Recognized Tribe: _____
 Pokagon Band Other Unrecognized Tribe: _____
 Sault Ste. Marie _____
 Huron Band of Potawatomi _____

Veteran Status: No Yes If Yes, Active Status: No Yes Reserves

Branch of Service: Air Force Army Coast Guard National Guard
 Navy Marines Other: _____

2. Insurance Information

Subscriber Name: _____

Subscriber Date of Birth: _____

Insurance Company: _____

Policy Number: _____

Claim Phone Number: _____

Group Number: _____

We will need a copy of the front and back of all insurance cards for billing purposes

3. Release of Information

First Name

Middle Name

Last Name

GTB Tribal ID

I hereby authorize the Grand Traverse Band of Ottawa and Chippewa Indians Behavioral Health Services to release or obtain information in my client records, including alcohol and drug abuse records protected under the regulations of 42 CFR Part 2, and/or HIPAA, to the individuals or organizations listed, and only the conditions listed:

Information to be released to/or obtained from: _____

Address

Phone Number

Relationship of person and/or organization to client: _____

Information to be released to/or obtained from: _____

Address

Phone Number

Relationship of person and/or organization to client: _____

Information to be released to/or obtained from: _____

Address

Phone Number

Relationship of person and/or organization to client: _____

SPECIFIC INFORMATION TO BE DISCLOSED

(initial all the apply)

_____ Appointment Arrangement

_____ Treatment Plan

_____ Emergency Info Only

_____ Assessment

_____ Continuing Care Plan

_____ Psychiatric Records

_____ Diagnosis

_____ Discharge Summary

_____ Other: Please Specify:

_____ Progress Reports

_____ Admission/Discharge Letter

_____ Psychosocial History

_____ Participation in Treatment

_____ Verification of Appointment

*Please note: Whether reports or documents are listed as singular or plural, it is inclusive of all reports or documents of that line

PURPOSE OR NEED FOR DISCLOSE

(initial all the apply)

_____ Continuation of Care

_____ Insurance and/or Billing

_____ Disability Determination

_____ Emergency Contact

_____ Social Service Referral

_____ Legal – Follow Up

_____ Referral – Follow Up

_____ Return to Work

_____ School

_____ Health Records/RPMS

_____ Grant Support

_____ Other: Please Specify:

GRAND TRAVERSE

CHARLEVOIX

LEELANAU

BENZIE

MANISTEE

ANTRIM

4. Signature Authorization

Client Signature

Date

Parent or Guardian, if applicable

Date

Witness Signature

Date

5. Revocation of Release

REVOCATION OF RELEASE

This consent may be revoked in writing by the signatory prior to its normal 12-month period of validity by signing below. This authorization is revoked for the following specific dates, events, or conditions

Date: _____ Event/Condition: _____

Client Signature: _____ Date: _____
(Sign here only if release is being revoked)

Staff Intake Notes;

