The Grand Traverse Band of Ottawa and Chippewa Indians

Behavioral Health Services

Intake Application

1. 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
☐ White
☐ Black/African American
☐ Hispanic
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Prefer Not to Say
☐ Other

Tribe:

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

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
_____ Assessment
_____ Diagnosis
_____ Progress Reports
_____ Psychosocial History
_____ Verification of Appointment
_____ Treatment Plan
_____ Continuing Care Plan
_____ Discharge Summary
_____ Admission/Discharge Letter
_____ Participation in Treatment
_____ Emergency Info Only
_____ Psychiatric Records
_____ Other: Please Specify:
_____
_____

*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
_____ Emergency Contact
_____ Referral – Follow Up
_____ Health Records/RPMS
_____ Insurance and/or Billing
_____ Social Service Referral
_____ Return to Work
_____ Grant Support
_____ Disability Determination
_____ Legal – Follow Up
_____ School
_____ Other: Please Specify:
_____

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;

_____
_____
_____
_____
_____
_____