The Grand Traverse Band of Ottawa and Chippewa Indians

Behavioral Health Services

FY24 Intake Application

1. Client Information

Date of Application: _____ GTB Tribal ID: _____

Other Federally Recognized Tribe Name and ID: _____

Client Name: _____

Minor Child Parent 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

* GTB only services clients in the six-county services area listed above; for all other counties, please contact us for a referral to your county's tribal affiliation.

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: _____

_____
Client Initials

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. Emergency Contact Information

Emergency Contact Name: _____ Phone Number: _____

4. Release of Information

The following are common entities that we may need to share information to and from in order to provide you with the best continuum of care in a timely manner; you must mark "no" after the appropriate line item if you do not want information disclosed to these entities. If no documentation is on file and you do not opt out on this form, we will assume that you are granting permission to release information to and from the following. You always have the right to revoke a release of information by completing Section 5 below at any time. A release of information is valid for 12 months from the date of signing unless you revoke your authorization.

- ✓ Grand Traverse Band Human Services 2300 Stallman Road Suttons Bay MI 49682_____
- ✓ Grand Traverse Band Anishinaabek Family Services 2300 Stallman Road Suttons Bay MI 49682_____
- ✓ Grand Traverse Band Medical Clinic 2300 Stallman Road Suttons Bay MI 49682_____
- ✓ Grand Traverse Band Tribal Court 2809 N West Bayshore Drive Suttons Bay MI 49682_____
- ✓ Munson Medical Center 1105 Sixth Street Traverse City MI 49684_____
- ✓ Addiction Treatment Services 1010 S Garfield Ave Traverse City MI 49686_____
- ✓ Pine Rest 1050 Silver Drive Traverse City MI 49684_____
- ✓ Traverse Health Clinic 1719 S Garfield Ave Traverse City MI 49686_____
- ✓ Seven Arrows Recovery 2491 W Jefferson Road Elfrida AZ 85610_____
- ✓ Recovery Syndicate 3140 N Arizona Ave Ste 101 Chandler AZ 85225_____
- ✓ Sanford West Behavioral Health 15146 16th Ave Marne MI 49435_____
- ✓ Little River Clinic and Behavioral Health 2840 Orchard Hwy Manistee MI 49660_____
- ✓ Little Traverse Bay Band Clinic and Behavioral Health 7500 Odawa Cir Harbor Springs MI 49740_____
- ✓ Saginaw Chippewa Clinic and Behavioral Health 2800 S Shepherd Rd Mount Pleasant MI 48858_____
- ✓ 86th District Court 280 Washington St Traverse City MI 49684_____
- ✓ 13th Circuit Court 328 Washington St Traverse City MI 49684_____

In addition to these common entities, you may choose to have us disclose information to and from others; please specify below:

- ☐ Family/Friend: _____ Phone: _____
- ☐ Legal.: _____ Phone: _____
- ☐ Medical Treatment: _____ Phone: _____
- ☐ Mental Health Treatment: _____ Phone: _____
- ☐ Other _____ Phone: _____

SPECIFIC INFORMATION TO BE DISCLOSED
(Initial or checkmark all the apply)

_____ Appointment Arrangement
_____ Assessment
_____ Diagnosis
_____ Progress Reports
_____ Psychosocial History
_____ Verification of appointment
_____ Treatment Plan
_____ Continuing Care Plan
_____ Discharge Summary
_____ Admission/Discharge
_____ 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 or checkmark 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:
_____

_____
Client Initials

5. Signature Authorization

Client Signature _____ Date _____

Parent or Guardian, if client is a minor _____ Date _____

Witness Signature, if required _____ Date _____

6. 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: _____

Revoking Authorization to release information to and from the following entities:

_____

_____

_____

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

Staff Intake Notes;

_____

_____

_____

_____

_____

_____