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: ______________________

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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

I voluntarily authorize the GTB BHS to access, use and share information about my care or the care of a client for whom I am the parent or legal guardian, with other treating providers for the purpose of integrated care. This access will be for the purpose of treatment including collaboration of care, payment, and other health care operations. I understand that substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records; 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my consent. 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 the form below, 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 will expire at the end of my Behavioral Health treatment, unless revoked prior to end of treatment.
I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, or if permitted by law. I understand that signing this form is voluntary but required in order to receive the full services provided by the GTB. I have been informed that I may request a copy of this form.

- ✓ 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

___X_ Appointment Arrangement	_____ Treatment Plan	_____ Emergency Info Only
___X_ Assessment	_____ Continuing Care Plan	_____ Psychiatric Records
___X_ Diagnosis	_____ Discharge Summary	___X_ Medication/Prescriptions
_____ Progress Reports	___X_ Admission/Discharge	_____ Other: Please Specify:
_____ Psychosocial History	_____ Participation in Treatment	
___X_ 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

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Client Initials

PURPOSE OR NEED FOR DISCLOSE

____X_ Continuation of Care	________X Insurance and/or Billing	________ Disability Determination
____X_ Emergency Contact	________X Social Service Referral	________ Legal – Follow Up
____X_ Referral – Follow Up	________ Return to Work	________ School
____X_ Health Records/RPMS	________ Grant Support	________ Other: Please Specify: ______________________________

5. Consent to Treatment and Disclosures

I voluntarily agree to the treatment and services which may be provided by the GTB BHS to me or to the client for whom I am the parent or legal guardian. I permit the GTB BHS, and the professionals involved in my care or the care of the client for whom I am the parent or legal guardian to use or disclose the health care information for purposes of treatment, payment, or healthcare operations including Case Conference Services as is applicable to my care.

If available as a current service, I authorize the GTB BHS staff to provide transportation. I release the GTB BHS staff from any liability in the performance of their transportation duties. I agree and understand that utilization of transportation services is a last resort after all other types of transportation have been exhausted, in accordance with the transportation policy. Contact BHS staff for availability and/or grant benefits.

I was provided a copy of the GTB BHS client handbook, have been given ample time to review the contents, additional disclosures, and consent, I have had an opportunity to ask questions, and am agreeing to services and/or grant benefits provided by BHS for behavioral health and/or substance use disorder treatment. I can request a copy of this document at any time.

I permit communication with GTB BHS via email, text messaging, Google scheduling/email app, and/or Calendly scheduling app, in order to set up appointments, send reminders, and for information regarding healthcare appointments and/or events. I understand that email and/or text communication over the internet or cellular network is not secure. Although it is unlikely, there is a possibility that information included in email and/or text can be intercepted and read by other parties.

I have received, read, and understood the GTB BHS Client Rights and Responsibilities document. I can request a copy of this document at any time.

I acknowledge that I have reviewed the GTB Notice of Privacy Practices/HIPAA Privacy Rule, which describes the ways in GTB BHS may use and disclose health care information for its treatment, payment, healthcare operations, and other permitted uses and disclosures. I can request a copy of this document at any time.

6. Signature Authorization

______________________________ ______________________________
Client Signature — Date

______________________________ ______________________________
Parent or Guardian if client is a minor — Date

______________________________ ______________________________
Witness Signature, if required — Date

7. Revocation of Release (SIGN ONLY IF REVOKING RELEASE)

REVOCATION OF RELEASE

This consent may be revoked in writing by the signatory prior to its normal period of validity by signing below. This authorization is revoked as of the date signed below.

Date: ________________________ Event/Condition: ____

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

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Client Signature: ______________________________________ Date: ____________________