THE PAIUTE INDIAN TRIBE OF UTAH

440 North Paiute Drive • Cedar City, Utah 84721 • (435) 586-1112 • (435) 867-2659 (Fax)

APPLICATION AND CONSENT FOR SERVICES

Behavioral Health Services

GENERAL INFORMATION

Client Name:	Date:
Parent(s) or Guardian Names (If applicant is under 18 years old):	
Date of Birth:	Current Phone Number:
Current Mailing Address:	**Reservation Location:** □ Cedar Area □ Shivwits/St. George □ Kanosh/Fillmore □ Richfield/Joseph □ Other:____________________________
Tribal Member: □ Yes □ No Which Band: □ Shivwits □ Cedar □ Indian Peaks □ Kanosh □ Koosharem Member of Another Tribe: □ Yes □ No Name of Tribe Enrolled with:________________________ (Include copy of CIB)	

INSURANCE INFORMATION

Insurance Name and Policy # (if covered by multiple policies, please list all that apply) - A current copy of your insurance card must be included with this application.

REASON FOR VISIT

Current Situation/Need: CHECK ALL THAT APPLY and BRIEFLY DESCRIBE

□ Mental Health Assessment/Counseling

Describe situation/Need: ____

□ Substance Abuse Counseling/Assessment - please list substance(s) used: ____

Describe situation/Need: ____

□ Other:__________________________

Describe situation/Need: ____

Assessment Due Date:**_________________________** *Reminder:* *Assessments may take several appointments to complete.*

Is the service Court-Ordered? (circle one) YES NO (Must provide a copy of your court documents.)

FAMILY PROFILE – Please include yourself in the family profile.

Members of Household First	Last	Relationship to Head of Household	Birth Date Mon	Day	Year	Sex	Tribal Enrollment Number
		Self					

Comments:

Consent for Services and Release of Information: My signature below indicates my consent for the PITU Behavioral Care Department to provide services to me and/or my child(ren). My signature also indicates that the information I provided above is accurate. In order to provide me with quality, integrated healthcare, I also authorize the PITU Behavioral Care Department to coordinate services within the Department and with the PITU Health Department as deemed necessary. Additionally, I approve the release of any and all information necessary to bill my insurance or other 3rd party payor.

Applicant Signature:____ **Date:**______________________

~~~~~VERY IMPORTANT THAT APPLICATION IS FULLY COMPLETED~~~~~
IF APPLICABLE, INCLUDE ALL REQUIRED DOCUMENTS

IF YOU HAVE COURT DOCUMENTS, PLEASE PROVIDE A COPY
or your application will be on hold

****THE DEPARTMENT HAS UP TO 30 DAYS TO DETERMINE ELIGIBILITY FOR SERVICES****