SUKAPI LODGE
MENTAL HEALTH CENTER

210 US Hwy 89 West
406-338-3200

APPLICATION FOR SERVICES

Sukapi Lodge Mental Health Center
Registration Form

Patient Information

First Name: Davw | Middle Initial: aspdisfh | Last Name: faijfpasojf

Address: sapdjasod | State: faspjfaspc | Zip: fsapoda

Date of Birth: aspjdaspjd | Preferred Name: aspojdaspojd

Gender: sadasdasd | Social Security #: dasopdjas

Are you unhoused? YES / NO: No

Do you have a vehicle for Transportation? YES / NO: No

Is this an Application for Services for an Adult or Adolescent? ADULT / ADOLESCENT: Adoles

Do you have access to the Internet? If yes, Where? *(Please circle)*

YES / NO: No

Home / Work / School / Clinic / Library / Community Center

Other : SDsad

Patient Family Information

Mother's Maiden Name: asddf | Marital Status: daofkpdfjjsdf

Father's Name: adpfjqpegoj

If the Patient is a minor, list the name of the Parent/Legal Guardian. Attach Doc *indicating custody or Guardianship, if applicable)*: dpafjsdpfj | Relationship to Patient: lkh

Emergency Contact Name: dsfsjdfpoj | Address: fdspofdsfj | Phone: sdifjdpsg234234

Contact Information

Mobile Phone: ;kjpijupoj | Email:

Home Phone:

Use this email to send appointment reminders. YES / NO: Yes

Work Phone:

Preferred Method of Communication

( ) Mail ( ) Mobile ( ) Home: Mail

( ) Email ( ) Work ( ) Other _

Patient Demographic Information

Ethnicity ( ) Latino or Hispanic

( ) Not Hispanic or Latino

( ) Unknown: Latino/Hisp

Race: American Indian/Alaskan Native

( ) American Indian/Alaskan Native ( ) Asian ( ) African American ( ) Hispanic/Latino ( ) Native Hawaiian or Pacific Islander ( ) Caucasian

( ) Other _____

Patient Demographic Information (Continued)

An enrolled member of a Federally Recognized Tribe? Yes | Name of Tribe

Tribal Enrollment #

If not enrolled, are you a descendant of a Federally Recognized Tribe?
YES / NO Yes

Religious Preference

Are you currently employed? YES / NO Yes

Employer Name, Address, Phone

Highest level of Education Achieved
( ) GED/HISET ( ) H.S. Diploma ( ) Some College
( ) Completed College

Employment Status
( ) Full-time ( ) Part-Time ( ) Seasonal Full-Time
( ) Other

Are you a U.S. Veteran? YES / NO Yes

Do you have V.A. Benefits? YES / NO Yes

Payment/Financial Information *(If you depend on another party's Insurance plan, please provide a copy of the card).*

Do you have Health Insurance? YES / NO

Full Name and D.O.B. of Insurance Card Holder:

What type of Insurance?
( ) Medical ( ) Medicare ( ) Healthy Montana Kids
( ) Dental ( ) Blue Cross/BlueShield ( ) Private
( ) Vision ( ) Medicaid

If you do not have any insurance, are you interested in a sliding fee scale? YES / NO Yes

If yes, please provide the following income information.
Monthly Income $
In Family or Annual income:

Release of Information/Assignement of Benefits: By completing this aplpication, I Authorize Sukapi Lodge Mental Health Center permission to release any information regarding my care to my insurance representative

Applicant Signature

Applicant | Parent/Legal Guardian (If Applicable)

Date | Current Phone #

PRIVACY ACT OF 1974: I understand that my Protected Health Information (PHI), either provided by me or collected by Sukapi Lodge Mental Health Center for my care, shall not be disclosed to any other individuals or agencies without my written consent. Furthermore, under this act, my three primary rights are to *(1)* Request records subject to exemptions, *(2)* Request changes to records if they are inaccurate, irrelevant, untimely, or incomplete, and *(3)* Protection from unwarranted invasions of privacy: This includes the collection, maintenance, use, and disclosure of personal information.

SLMHC staff will complete this portion of the application. Application received on Date___