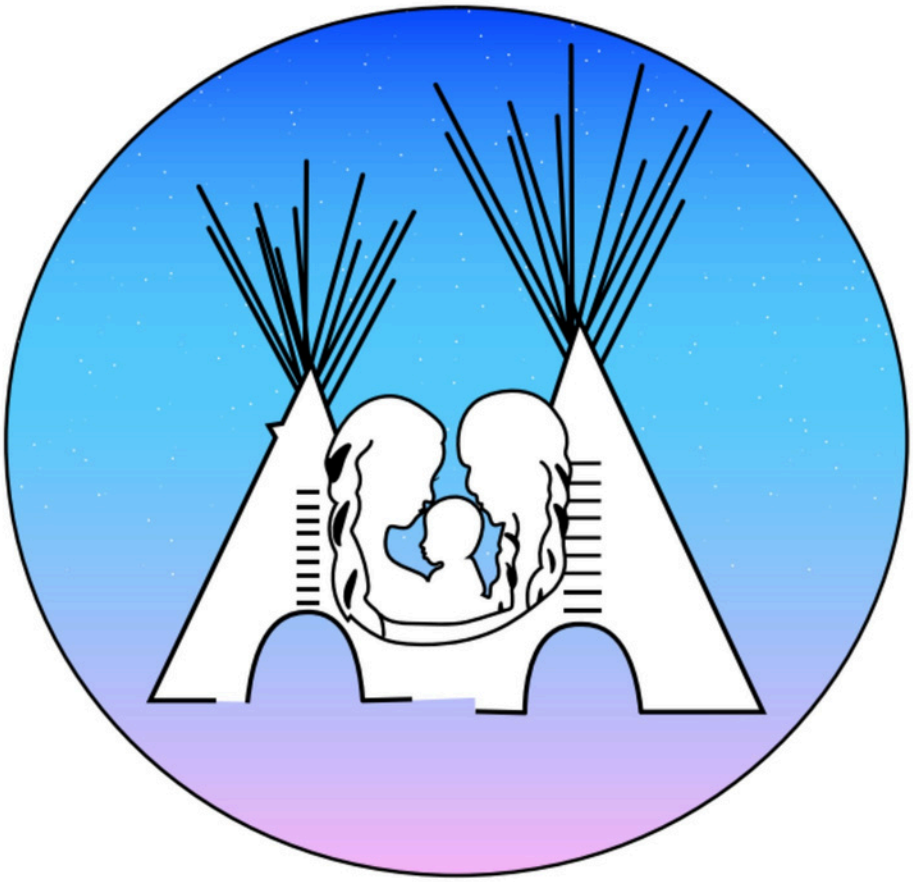
SUKAPI LODGE
MENTAL HEALTH CENTER

210 US Hwy 89 West
406-338-3200



APPLICATION FOR SERVICES

Sukapi Lodge Mental Health Center
Registration Form

Patient Information

First Name	Middle Initial	Last Name		
Address			State	Zip
Date of Birth		Preferred Name		
Gender	Grade Level	Social Security #		
Are you unhoused? **YES / NO** No Do you have a vehicle for Transportation? No Is this an Application for Services for an Adult or Adolescent? **ADULT / ADOLESCENT** Adolescent		Do you have access to the Internet? If yes, Where? (Please circle) **YES / NO** No Home / Work / School / Clinic / Library / Community Center Other : _ Other __		

Patient Family Information

Mother's Maiden Name	Marital Status
Father's Name	
If the Patient is a minor, list the name of the Parent/Legal Guardian. Attach Doc indicating custody or Guardianship, if applicable)	Relationship to Patient

Emergency Contact Name	Address	Phone

Contact Information

Mobile Phone	Email
Home Phone	Use this email to send appointment reminders. **YES / NO** No
Work Phone	Preferred Method of Communication ( ) Mail ( ) Mobile ( ) Home Other ( ) Email ( ) Work ( ) Other

Patient Demographic Information

Ethnicity ( ) Latino or Hispanic ( ) Not Hispanic or Latino ( ) Unknown Unknown	Race ( ) American Indian/Alaskan Native ( ) Asian ( ) African American ( ) Hispanic/Latino ( ) Native Hawaiian or Pacific Islander ( ) Caucasian ( ) Other Other _____

Patient Demographic Information (Continued)

An enrolled member of a Federally Recognized Tribe? No	Name of Tribe
Tribal Enrollment #	If not enrolled, are you a descendant of a Federally Recognized Tribe? YES / NO No
Religious Preference	Are you currently employed? No
Employer Name, Address, Phone	Highest level of Education Achieved Completed C ( ) GED/HISET ( ) H.S. Diploma ( ) Some College ( ) Completed College
Employment Status ( ) Full-time ( ) Part-Time ( ) Seasonal ( ) Other Other _____	Are you a U.S. Veteran? No Do you have V.A. Benefits? No

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

Do you have Health Insurance? 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 Medicaid
If you do not have any insurance, are you interested in a sliding fee scale? No	If yes, please provide the following income information. Monthly Income $ _____ or Annual income: _____ # In Family _____

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 _____

SUKAPI LODGE MENTAL HEALTH CENTER

210 US HWY 89 WEST, Browning MT, 59417

Emergency Numbers:

Sukapi Lodge	406.338.3200/406.338.3250
Crisis Line text NATIVE to	741741
Crisis Service for LGBTQ2S (Trevor Project)	1.866.7386
Trans Lifeline	1.877.565.8860
Drug Hotline	1.877.338.6146 (DRUG)
National Suicide Prevention Hotline	1.800.273.8255
IHS* Behavioral health	1.406.338.6146
IHS* Emergency Room	406.338.6100
BIA Law Enforcement	1.406.338.4000
Suicide Prevention Hotline	*988

The following numbers were given to the patient upon discharge from the program to use for services and are available at any time for any reason. This notifcation of services is provided by Sukapi Lodge Mental Health Center staff.

Patients name: _____ Date _____

Sukapi Staff: _____ Date _____

SUKAPI LODGE MENTAL HEALTH CENTER (SLMHC) Subject: OATH OF CONFIDENTIALITY	REFERENCE: SL-CLIN
DEPARTMENT: General Program Standards (Service Structure)	EFFECTIVE: 8/8/2024
APPROVED BY: Blackfeet Tribal Health Department	REVISED: 4/22/2022

The undersigned individual agrees not to divulge, publish, or otherwise make known any information concerning a client of Sukapi Lodge Mental Health Center (SLMHC) while entering the facility. Any client information may only be discussed or shared in context with the understanding that either internal or external providers have a "Release of Information" signed by the client authorizing their permission to share pertinent Protected Health Information (PHI).

Visitors or members of the public may not discuss information or individuals who they encounter on the property of Sukapi Lodge. *Al/federal guidelines about the Health Insurance Portability* & *Accountability Act (HIPAA) and 42 CFR, part 2' will* be *adhered to.*

Exceptions:

1. The client may provide *written consent* for the release of information concerning him/her. *(Ex: handwritten note allowing exposing their confidential location as being in treatment or receiving care.)*

2. Information may be released as required by appropriate federal or state laws and regulations.
3. *Information relating to child abuse must be reported. Staff, Clients, and visitors must be notified of this law.*

4. Any exceptions will be directed through the Clinical Coordinator or Director of SLMHC.

In receiving, storing, and otherwise dealing with any information about clients, the undersigned is legally bound by the requirements of the Code of Federal Regulations (CFR) 42, Part II (Federal Regulations on Confidentiality of Alcohol and Drug Abuse Records), HIPAA, as well as by State and Tribal Statutes governing confidentiality.

The undersigned further acknowledges that any unauthorized disclosure of client information or records may subject the undersigned to a civil action for damages and/or violation of this law.

_____ _____

Visitor's Signature Date

_____ _____

Parent/Legal Guardian Signature Date

This notice accompanies a disclosure of information concerning a patient's alcohol/drug abuse treatment made to you with the consent of such a patient. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part2) and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA 45 C.F.R. Parts 160 & 164) Federal laws prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person *to* whom it pertains or as otherwise permitted by 42 CFR Part 2 of HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules and laws restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. CCLTC will not make signing this authorization a condition of treatment, payment, or enrollment/eligibility for benefits

SUKAPI LODGE

RELEASE OF LIABILITY/WAIVER

I, _____ , undersigned, do hereby release the Sukapi Lodge Mental Health Center from any and all liabilities while I am participating in my substance use disorder treatment. I recognize that participation in any CCLTC activity is my right to accept or deny in accordance with the client handbook. My participation may involve inherent risks, including risk of physical or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent paralysis and/or death, and I assume all related risks and voluntarily participate in any CCLTC activities.

I agree to indemnify release against any and all claims, actions, lawsuits, damages and judgments, including attorney's fees, arising out of or relating to my participation in the Activity.

This release shall be binding upon the parties and their respective heirs, administrators, personal representatives, executors, successors, and assigns. I have the authority to release the Claims and have not assigned or transferred any Claims to any other party. The provisions of this release are severable. If any provision is held to be invalid or unenforceable, it shall not affect the validity or enforceability of any other provision. This Release constitutes the entire agreement between the parties and supersedes any prior oral or written agreements or understandings between the parties concerning the subject matter of this Release. This Release may not be altered, amended or modified, except by a written document signed by both parties. The terms of this Release shall be governed by and construed in accordance with the laws of the State of Montana and the Blackfeet Tribe.

*******I have carefully read and fully understand all the provisions of this Release and am freely. knowingly and voluntarily entering into this Release.*

_____ _____

Client signature Date

_____ _____

Counselor name Date

SUKAPI LODGE MENTAL HEALTH CENTER (SLMHC) Subject: RECEIPT OF ACKNOWLEDGEMENT	REFERENCE: SL-CLIN PAGE: 1 OF: 1
DEPARTMENT: General Program Standards (Service Structure)	EFFECTIVE:
APPROVED BY: Blackfeet Tribal Health Department	REVISED:

I,_____ understand my rights, responsibilities, and expectations outlined by the Sukapi Lodge Mental Health Center client handbook. Whereas I acknowledge that I understand all that the outpatient staff member explained and read to me from the admissions packet.

By signing this form, I acknowledge I have fully read and agree to adhere to them while I am a client of Sukapi Lodge. This signed receipt verifies my understanding.

Client Signature: _____

Client Printed Name: _____

CCLTC Staff member: _____

Date: _____

Acknowledgement received by: _____

SUKAPI LODGE
GRIEVANCE PROCEDURE

POLICY:

It is the policy of Sukapi Lodge to provide every client with the right to considerate and respectful care while a client in the facility. If a client feels that staff and/or organization have violated their client rights, they have the right to grieve. They will be assisted in accessing a *Grievance procedure ,* in accordance with *37.27.116, (h) 'Client Rights.'*

PROCEDURE:

1. The client will put in writing their grievance and submit to his/her primary counselor. The primary counselor will have *two (2) days* to resolve this conflict. The Primary Counselor will make a decision in writing notifying the client of his/her decision. If client is satisfied with this decision, no further action will be necessary. However, if client is not satisfied with this decision, all information related to this conflict will be brought to the Clinical Coordinator for the next step.

2. The Clinical Coordinator will have *two (2) days* to resolve this conflict. The Clinical Coordinator will make a decision in writing notifying the client of his/her decision. If the client is satisfied with this decision, no further action will be necessary. However, if the client is not satisfied with this decision, all information relating to this conflict will be brought to the Director where the final decision will be made.

3. The Director will have *two (2) days* to make a final decision on the conflict submitted by the client. The Director's decision will be in writing to the client notifying of the decision, which will be final.

4. The client will be extended assistance and referral to an appropriate resource for advocacy. Filing a grievance is a client's right, therefore, it is the responsibility of the staff to honor and respect the client's actions. At no time, will a client be discharged for filing a grievance.

5. The client will be made aware of the availability of an external review.

6. *Grievance forms* will be obtained from the counselors or the unit technicians on duty. *The client will be made aware of this right and the location of the forms during the orientation.*

7. In the event a grievance is filed against the primary counselor, clinical coordinator, or the director, the grievance may proceed to their immediate supervisor for completion.

Client Signature _____ Date _____

SLMHC Staff Member _____ Date _____

SUKAPI LODGE MENTAL HEALTH CENTER
210 US Highway 89 West – Browning Mt. 59417
406-338-3200

Patient Name: _____
_____ _____

DOB: _____ SS#_____ _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Extent or nature of disclosure is limited to: (Check all that apply). HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

☐ Continued Care Plan/Transition/Discharge ☐ History & Physical

☐ Mental Health Assessment ☐ Treatment Plan ☐ Progress Notes

☐ Physical Orders ☐ Dates in program ☐ Medication Records

☐ General Progress in Treatment ☐ TB Skin Test Results ☐ Interdisciplinary Notes

☐ Continued Stay Reviews ☐ Correspondence ☐ Recovery House

☐ Application ☐ BioPsychoSocialEval/Assessment

Date Release Revoked: _____
Other (Please be specific)
_____
_____
Purpose of need for disclosure is:
_____
_____
_____
_

Permission is hereby given to EXCHANGE information with:

Sukapi Lodge Mental Health Center
210 US Highway 89 West
Browning, Mt. 59417 phone: 406.338.3200
AND

Name:_____
Address:_____
City:_____ State:_____ Zip Code: _____
Phone Number:_____ Fax Number: _____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

I, the undersigned, have read the above and authorize staff of the disclosing facility named to disclose such information as herein contained. I understand that I may revoke or cancel this authorization at any time. Withdrawal of the authorization does not affect any information disclosed before providing a written notice of such a withdrawal of authorization. This authorization will remain in effect for 180 days in order to carry out the purpose for which my permission was given. I understand that the program releasing these records is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the information that is to be disclosed and who can see this information. A photocopy of this authorization is as valid as the original.

I Cancel My Permission To Disclose The Information Described On This Form. Patient Signature Date

Approved: April 2003 This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part2) and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA 45 C.F.R. Parts 160 & 164) Federal laws prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 of HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules and laws restrict any use of the information to criminally investigate of prosecute any alcohol or drug abuse patient.

_____ Patient Signature and Date

_____ Parent (Legal Guardian) Signature and Date

I cancel my Permission to Disclose the Information Described on This Form.

_____ **Patient Signature and Date**

_____ **Parent (Legal Guardian) Signature and date**

This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part2) and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA 45 C.F.R. Parts 160 & 164) Federal laws prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 of HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules and laws restrict any use of the information to criminally investigate of prosecute any alcohol or drug abuse patient.

Sukapi Lodge will not make signing this authorization a condition of treatment, payment or enrollment/eligibility for benefits unless the authorization is mandatory.

CLIENT RIGHTS

(1) The client rights policy under the Administrative Rules of Montana 37.106.1450 supports and protects all clients' state and federal constitutional and statutory rights, including civil rights. These must include the right to:

(a) Receive treatment free of unlawful discrimination;

(b) Receive reasonable accommodations, consistent with federal and state law;

(c) Receive treatment in the least restrictive environment, consistent with law, in a manner sensitive to individual needs and which promotes dignity and self-respect;

(d) Have clinical and personal information treated in accordance with state and federal statutes and regulations;

(e) The opportunity to review their own treatment records in the presence of the administrator or designee, consistent with 45 CFR 164.524 and other state and federal confidentiality statutes and regulations;

(f) Be fully informed of fees charged, including fees for copying records to verify treatment and methods of payment available;

(g) Be free from abuse, neglect, harassment, and financial exploitation by staff members or clients;

(h) Have grievances considered in a fair and timely manner, with respect to infringements of rights described in this rule;

(i) Educational services provided to adolescents within inpatient/residential settings in accordance with Montana state law;

(j) Client orientation to SUDF rules, responsibilities, and any sanctions that may be imposed for failure to comply with the SUDF rules;

(k) Reasonable visitation and access to telephone communication within inpatient/residential settings;

(l) Send and receive mail within inpatient/residential settings;

(m) Regular physical exercise several times per week within inpatient/residential settings; and

(n) Be given a 30-day notice in the event of a SUDF closure or treatment service cancellation and:

(1) Provided assistance with relocation into similar treatment services, if available;

(2) Be given refunds to which the client is entitled; and

(3) Be advised how to access records to which the client is entitled.

I _____ have acknowledged the rules and fully understand my *client's rights* policy, treatment methods, and regulations applicable.

_____
_____
Client signature Date:

_____
_____
SLMHC staff signature Date:

Sukapi Lodge Mental Health Center
APPLICATION

SCAN ME