



Vinland National Center Application for Residential Treatment

Full legal name _____

Date of birth _____

Social security # _____

Primary Phone # _____ Secondary Phone # _____

Address _____

County _____

Marital status _____ Race _____

Enrolled in a tribe? _____ Name of Tribe _____

Do you receive SSI or SSD? _____ How much? _____

Emergency Contact: Emergency contact name _____

Relationship _____ Phone # _____

Guardian: Yes or NO If yes Name of Guardian _____

Phone number# _____

Please attach/send copy of guardian paperwork.

Commitment status:

Full commitment Stay of commitment

Please attach/send copy of commit paperwork.



Probation: YES or NO Probation officer name _____

PO phone# _____ County _____

Primary physician: Clinic name _____

Dr. Name _____

Clinic phone # _____ Clinic fax# _____

Insurance info: Medicaid (medical assistance), Pre-paid health plan, Medicare, commercial policy
Required

Complete all that apply:

Insurance company _____

ID # _____

Insurance company _____

ID # _____

Insurance company _____

ID # _____

Please attach/send a copy of insurance card/s

Does client have a rep-payee? YES or NO

Rep-Payee Name _____

Rep-Payee phone _____