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# _____

Mental Health Therapist: Name: _____

Clinic Name:_____Tel.# _____

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 _____