Benteh Wellness Center
New Participant Intake Form

PLEASE SEND INTAKE FORM TO BWCREFERRALS@KNIKTRIBE.ORG

All applicable fields are required. Missing information may delay referral process.
Please contact Benteh Wellness Center at 907-671-6871 with any questions.

TODAY'S DATE: _____ PERSON FILLING OUT THIS FORM: _____

REFERRING AGENCY: _____ OR ☐ SELF CONTACT EMAIL: _____

PARTICIPANT INFORMATION

NAME: _____ EMAIL: _____

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER: _____

PHONE NUMBER: _____ SOCIAL SECURITY NUMBER: _____ (Required if not providing FULL insurance info)

PREFERRED PRONOUN: _____ RACE: ☐ ALASKA NATIVE/AMERICAN INDIAN ☐ OTHER: _____ TRIBAL AFFILIATION:_____

PARENT NAME: _____ PARENT PHONE NUMBER: _____ CUSTODY %: _____

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EMERGENCY CONTACT: _____ CONTACT PHONE #: _____ RELATIONSHIP_____

REQUIRED BY STATE OF ALASKA: Is the participant pregnant? ☐ Yes ☐ No Is the participant using injectable drugs? ☐ Yes ☐ No
If yes to being pregnant AND using injectable drugs, please contact 907-671-6863 immediately.

LIVING ARRANGEMENT

☐ Home with Parents ☐ Alone ☐ Living with Relatives ☐ Living with Non-Relatives ☐ Homeless
☐ Foster Care ☐ Shelter ☐ Transitional Housing ☐ Assisted Living ☐ Other: _____

MAILING ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____ OCS INVOLVEMENT: ☐ YES ☐ NO

LEGAL GUARDIAN: _____ PROBATION OFFICER: _____

REASON FOR TREATMENT

In your own words, describe the participant in need of mental health services. Please describe specific behaviors the participant is exhibiting:

Where do these behaviors usually occur? ☐ Home ☐ School ☐ Community

TREATMENT HISTORY

Is the participant currently receiving or has ever received Behavioral Health Services and/or Substance Abuse Treatment or support? ☐ YES ☐ NO

If yes, where? _____ When? _____

Is the participant currently taking medications? ☐ YES ☐ NO If yes, what medications? _____

Physician Name: _____

ADDITIONAL INFORMATION

Does the participant need special assistance to attend their appointment? ☐ YES ☐ NO If yes, please describe:_____

Preference for Therapy: ☐ MALE ☐ FEMALE ☐ FIRST AVAILABLE Current School:_____

PAYMENT INFORMATION

PAYER NAME: ☐ MEDICAID ☐ OTHER: _____ INSURANCE ID #: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____ SUBSCRIBER SSN: _____