Application Information

Applicant's Information

Name:			VMH #:	
Former:		SS #:	Birth Date:	
Address:		City:	State:	Zip:
Home #	Cell #	Work #	Email:	

Referral Source

Name:		Title:	
Phone #:		Agency:	
Address:	City:	State:	Zip:

Emergency Contact

Name:		Relationship:		
Address:		City:	State:	Zip:
Home #	Cell #	Work #	Email:	

Directory of Individuals Involved in My Care

Valley Behavioral Health complies with HIPAA. These regulations allow us to share your protected healthcare information with others that you consider part of your care. This can include healthcare providers. To release or share information with any other party (i.e., family, friends, or agencies) a Release of Information form is required. Substance abuse treatment records require a signed Release of Information form. For additional space, request an addendum form.

Other Contact *(if not listed as emergency contact.)*

Name:		Relationship:		
Address:		City:	State:	Zip:
Home #	Cell #	Work #	Email:	

Primary Care Physician

Name:	Specialty:		
Address:	City:	State:	Zip:
Office #:			

_____ **No Primary Care Physician (initial)**

Acknowledgements & Consent

Initial each handout received:

____ **Privacy Notice:** The Privacy Notice tells you how we may share your protected health information. It lets you know when your permission is required. Read the Privacy Notice carefully.

____ **Advance Healthcare Directive** *(adult)***:** This legal document allows you to let others know your health care wishes. This is used when you cannot communicate.

____ **Rights & Responsibilities:** This describes your rights and responsibilities as a client.

____ **Program Specific Guidelines** *(optional)***:** Program specific guidelines will be given to you at admission.

____ **Medicaid Handbook:** I have been offered the Medicaid Handbook. I understand that the purpose of the Medicaid Handbook is to explain my benefits, covered services, rights & responsibilities, how to choose a provider, and how to access transportation and emergency services.

Emergency Medical Care - I consent to receive first aid and emergency medical treatment. This would be if I have an accident, injury, illness, or medical emergency. I understand this is only during treatment with Valley. This also applies to minors admitted by a parent or guardian.

Consent - I certify the above information is accurate and complete. I consent to treatment and testing/assessment at Valley Behavioral Health. I understand testing includes, but is not limited to, intellectual/cognitive, developmental, etc.

Applicant's Signature ▶		Date ▶
If Minor, Authorized Representative Signature ▶		Date ▶
Printed Name of Authorized Representative ▶		Relationship ▶
Witness Signature ▶	Printed Witness Name ▶	Date ▶

Office use only: ID Used (attach copy to this form) ☐ Utah Driver's License ☐ Other Picture ID ☐ Other:

Application Addendum

Directory of Individuals Involved in My Care

Client Name:	Valley #:
Birth Date:	

Other Contacts - Family & Friends				
Name:		Relationship:		
Address:		City:	State:	Zip:
Home #	Cell #	Work #:	Email:	

Name:		Relationship:		
Address:		City:	State:	Zip:
Home #	Cell #	Work #:	Email:	

Name:		Relationship:		
Address:		City:	State:	Zip:
Home #	Cell #	Home #	Email:	

Name:		Relationship:		
Address:		City:	State:	Zip:
Home #	Cell #	Work #:	Email:	

Health Care Providers			
Name:	Specialty:		
Address:	City:	State:	Zip:
Office #			

Name:	Specialty:		
Address:	City:	State:	Zip:
Office #			

Name:	Specialty:		
Address:	City:	State:	Zip:
Office #			

If this is an update, please sign below:

Applicant's Signature ▶	Date ▶
If Minor, Authorized Representative Signature ▶	Date ▶
Printed Name of Authorized Representative ▶	Relationship ▶
Witness Signature ▶	Date ▶