Comanche Nation Prevention & Recovery
Outpatient Treatment Center

Mental Health Counseling and Treatment Application

The Mission of the Comanche Nation Mental Health Counseling and Treatment program is to provide assistance to enrolled federally-recognized tribal members seeking counseling and/or mental health related treatment. Eligible applicants may receive assistance for clincial sessions with a licensed therapist for mental health treatment.

Applicants must meet all eligibility requirements and provide the requested documents in order to be considered for counseling through the Comanche Nation Prevention & Recovery Outpatient Treatment Center.

Mailing address:
Comanche Nation Prevention & Recovery
Outpatient Treatment Center
P.O. Box 908 Lawton, OK 73502

Physical address:
807 SW F. Ave Lawton, OK 73501

Phone: 580-357-3449 Fax: 580-354-9211

Email:
prevention.recovery@comanchenation.com

Comanche Nation Prevention & Recovery
Outpatient Treatment Center

Mental Health Counseling and Treatment Application

Please answer each category completely. If it does not apply, answer (N/A) non-applicable. Incomplete applications may result in the denial of services.

Client Information: (Please Print Clearly)

First Name: _____ MI: _____ Last Name: _____

Tribal Affiliation:_____ Date of Birth: _____/_____/_____ Age: _____

Primary telephone number: _____ Email: _____

Client Mailing Address: _____
City *State* *Zip*

Client Physical Address: _____
(if different from mailing) *City* *State* *Zip*

Emergency Contact Name: _____ Telephone Number: _____

Legal Guardian Information: (if client is under the age of 18)

First Name: _____ MI: _____ Last Name: _____

Tribal Affiliation:_____ Date of Birth: _____/_____/_____

Primary telephone number: _____ Secondary telephone number: _____

Are you currently receiving mental health services or counseling? (please circle): Yes or No
Have you ever received mental health services or counseling in the past? (please circle): Yes or No
If so, did you receive any diagnosis? (**Documentation needed**) Diagnosis: _____

Please provide a brief statement/reason/need for counseling or treatment.

_____

_____

_____

I affirm that the information in this application is correct to the best of my knowledge. I understand that all services and/or funding are subject to the availability of funds and approval of the Director.

Client/Legal Guardian Signature Print Date

Staff Signature Title Date

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Please answer each category completely. If it does not apply, answer (N/A) non-applicable. Incomplete applications may result in denial of services. If you do not have a counselor selected, we can refer you to one.

Referral Location: (Please Print Clearly)

Office/Facility:

_____

Counselor/Facility Point of Contact: _____ License #:_____

Telephone number: _____ Fax Number: _____

Email: _____

Address: _____

City *State* *Zip*

Estimated Costs:

The facility must be willing to accept a promise to pay from the Comanche Nation. An invoice and W9 is required for financial assistance and must be included with this application before processing payment.

Statement of Understanding:

I affirm that the information in this application is correct to the best of my knowledge. I understand that all services and/or funding are subject to the availability of funds and approval of the Director. By signing this statement, I agree that I am responsible for scheduling all appointments and will attend sessions as scheduled. I agree that I will not cancel any appointment without proper notice as required by the therapist and/or clincial office. Payment will not be provided for any session that I do not attend the full amount of time allotted. I am responsible for any fee that may incur if I am late or cancel. I understand that payment will be made only once a bill is received by the Comanche Nation Prevention & Recovery from the referral location listed above.

Client/Legal Guardian Signature Print Date

Staff Signature Title Date

Release of Confidential Information:

Comanche Nation Prevention & Recovery
Outpatient Treatment Center

Client Name: _____ DOB: _____ SSN: _____

If you do not provide a complete address, to include street, city and zip code, **notification of your inquiry will not be mailed.**

I hereby authorize**:**

Comanche Nation Prevention & Recovery
Outpatient Center
807 S.W. F Ave Lawton, OK 73501
580-357-3449

To release my confidential information to:

Name of person to receive information: _____

Organization: _____

Address: _____

City, State, & Zip Code: _____

Phone number: _____ Email:_____

- **Information may include, but not limited to protected health information such as mental health and substance abuse records.**
- **I understand that my mental health records are protected under HIPAA (Health Insurance Portability and Accountability Act) and cannot be released without my written consent.**
- **I understand that my substance abuse records are protected under Federal and State Confidentiality Regulation (42: CFR) and cannot be released without my written consent.**
- **I understand that I may revoke this authorization, in writing at any time, except for actions that may have already taken place prior to the date on my written revocation.**
- **In any event, this consent expires automatically ninety (90) days after the termination of current services.**
- **I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.**
- **I acknowledge the release of confidential information was fully explained to me and I consent.**
- **I have the right to receive a copy of this authorization.**

Client/Legal Guardian Signature Print Date

Staff Signature Title Date