Apache Behavioral Health Services, Inc.

Form 10.3
WHITE MOUNTAIN APACHE TRBHA
ADMISSION CONTACT FORM

Client Name: _____

Client Date of Birth: _____

Client Social Security #: _____-____-_____

AHCCCS ID: (if Known): _____

Emergency Contact for Client: Name: _____ **Phone:** _____

Date and Time of Admission: _____

Name of Admitting MD: _____

Diagnosis at Admission: _____

Contact Person at Facility: _____

Facility Contact: Phone: _____ **Fax:** _____

If IMD provider type 71 or B6 attach signed copy of notification that AHCCCS eligibility will end if length of stay is in excess of 30 days.

Please complete this form and Fax to (928) 338-4930 Attention: Out of Home Coordinator within the first 24 - 72 hours of Admission.