BIE BHWP Referral Form

*Please note that this form will be completed during a virtual referral intake session and completed forms should **not** be sent to the BHWP at any time to ensure the protection of your confidential information.*

Request for BIE Behavioral Health and Wellness Program (BHWP):
☐ Counseling
☐ Resources

Referred by (check all that apply):
☐ Self ☐Custodial parent/Legal Guardian
☐ Counselor ☐ Other _____
☐ Teacher
Referral Name and Contact Information: _____

Client's Full Name:

_____
Preferred Name:

_____
Custodial Parent/Legal Guardian Information:
If under the age of 18, parent/legal guardian's name: _____

Date of Birth: _____
School Affiliation:

_____
Department Affiliation (if adult)

_____
Tribal Affiliation or Tribal Enrollment:

_____

Mailing address (if minor, parent/legal guardian address):
Address/P.O. Box:

_____
City: _____ State:

_____
Zip Code:

_____

Physical address (if different from mailing address):
Physical Address:

_____

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City: _____ State: _____

Zip Code: _____

Contact information (if minor, parent/legal guardian phone):
Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Preferred phone for contact:
☐ Home ☐ Cell

If a cell phone, do you agree to receive text messaging regarding appointment times, emergency contact, or other necessary contact times?
☐ Yes ☐ No

Status
☐ Student
Grade Level _____
☐ Staff Member/Faculty
☐ Student Family Member

Gender/Orientation:
☐ Male
☐ Female
☐ Self-identify as _____
☐ Prefer not to respond

Preferred Pronouns (he/him, she/her, they/them):

Emergency Contact Information:
Emergency Contact
Name: _____
Emergency Contact Phone Number: (_____) _____

Emergency Contact relationship to client: _____

Secondary Emergency Contact
Name: _____

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Secondary Emergency Contact Phone Number: (_____)

_____

Secondary Emergency Contact relationship to client: _____

Reason for Referral:

_____

_____

_____

_____

As applicable:
Local or preferred hospital or emergency room nearest your physical location:
Hospital or ER address: _____
Hospital or ER Phone Number:

_____

L**ocal EMS, Law Enforcement Department or Community Health Office:**
EMS Contact Number: _____
Local Law Enforcement Contact Number: _____
Community Health Office: _____

Privacy Act Statement: This information is collected pursuant to the provisions of the Privacy Act of 1974, as amended, under the Department of the Interior (DOI) Privacy Act system of records, INTERIOR/BIE-02, Behavioral Health and Wellness Program. This system helps the Bureau of Indian Education (BIE), Behavioral Health and Wellness Program (BHWP), provide immediate behavioral health crisis support, clinical counseling services, crisis care coordination, and communication with the client and appropriate points of contact for referrals and continued service delivery or emergency care. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b), all or a portion of the records or information contained in this system may be disclosed outside DOI as a routine use pursuant to 5 U.S.C. 552a(b)(3).

Paperwork Reduction Act Statement: We are collecting this information subject to the Paperwork Reduction Act (44 U.S.C. 3501) to provide indigenous focused, evidence-based, and trauma-informed behavioral health and wellness services/resources for students and staff at all Bureau-funded programs,

departments, and institutions including Bureau operated schools, Tribally controlled schools, post-secondary institutions, and Tribal colleges and universities. Your response is voluntary, and we will not share the results publicly. We may not conduct, or sponsor and you are not required to respond to a collection of information unless it displays a currently valid OMB Control Number. OMB has reviewed and approved this form and assigned OMB Control Number 1076-0122, which expires ##/##/####.

Estimated Burden Statement: We estimate this form will take BHWP staff, via staff and/or student virtual referral intake interviews, 30 minutes to complete, including time needed to read instructions, gather information, complete, and submit the form. Please note that this form will be completed during a virtual referral intake session and completed forms should **not** be sent to the BHWP at any time to ensure the protection of your confidential information. You may submit comments on any aspect of this information collection to the Information Collection Clearance Officer, Office of Regulatory Affairs & Collaborative Action—Indian Affairs (RACA), U.S. Department of the Interior, 1001 Indian School Road NW, Suite 229, Albuquerque, NM 87104.