Inuvialuit Regional Corporation

Non-Insured Health Benefit (NIHB) – Mental Health Counselling (MHC)

Client Application

Eligible services under the benefit may include:

- Initial assessment sessions (maximum 2 hours) performed by a registered provider
- Counselling sessions up to a maximum of 20 hours per 12-month period (exceptions for additional hours of counselling may be provided on a case-by-case basis
- Sessions may be individual, family, or group counselling

Except for the initial assessment, all additional counselling services must be prior approved by the Inuvialuit Regional Corporation and service provider. The service provider must be enrolled (or eligible for enrolment) with the NIHB program.

Client Eligibility:

- Be a Canadian Resident
- Be a registered Inuvialuit Beneficiary or an enrolled Gwich'in Participant
- Have an Inuit N Number or Gwich'in Enrolment Number
- Have a valid Provincial/Territorial Health Care Card

Email completed application to counselling@inuvialuit.com or drop off to the Health & Wellness Division, 1st Floor Inuvialuit Corporate Centre

Client Information:

Client Surname:	Client Given Names:
Date of Birth: D/M/Y / /	Inuvialuit File Number or Gwich'in Enrolment Number:
Health Care Number:	Inuit N Number:
Home and Mailing Address:	Email address: Phone Number:

Applicant Signature: _____Date: _____

Inuvialuit Regional Corporation

Consent for Release of Information

This Consent of Release of Information allows registered providers and the Inuvialuit Regional Corporation to communicate information as required and may include:

- Number of sessions, including proposed number of counselling hours
- Dates of sessions, including initial assessment
- Identifying information

I understand that no other information will be released to any person without my written consent. e.g.: Any information that breaches client/counsellor confidentiality.

I, _____, have read and understand above written
Client Name
information, and hereby authorize the Inuvialuit Regional Corporation and

_____,
Registered Service Provider
to release the afore mentioned information as required.

In order for this release to be valid, this form must be completed and signed by the client and witnessed.

Print Client Name:	Signature of Client:	Date: D/M/Y / /
Print Name of Witness:	Signature of Witness:	Date: D/M/Y / /

For Provider Use Only:

Provider Name, Professional Designation: _____

Legislated Regulatory Body: _____

Registration Number: _____

Signature: _____ Date: _____

Email:_____ Phone:_____

For Office Use Only:

□ Approved □ Reason Denied _____

Signature: _____ Date _____