

# Rimrock Trails Adolescent Treatment Services

[www.rimrocktrailsats.com](http://www.rimrocktrailsats.com)

Residential & Outpatient Main Campus: 1333 NW 9<sup>th</sup> St., Prineville, OR 97544 - (541)447-2631

Redmond Outpatient Office: 413 SW 8<sup>th</sup> St., Redmond, OR 97756 - (541)617-4771

Bend Outpatient Office: 63360 Britta St. Bldg. #1, Bend, OR 97701 (541)388-8459

## FINANCIAL/CLIENT APPLICATION

### Please complete all information

Today's Date: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

CLIENT NAME \_\_\_\_\_ DOB: \_\_\_\_\_ Client # \_\_\_\_\_

SS# \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Tattoo's/Scar: \_\_\_\_\_

Eye: \_\_\_\_\_ Hair: \_\_\_\_\_ Grade: \_\_\_\_\_

Request for: Deschutes County SE 66 Funds \_\_\_\_\_ Cascade Youth Family RHI Funds: \_\_\_\_\_

Person Providing Service: \_\_\_\_\_

Level Of Care  Assessment & Date: \_\_\_\_\_  Educational .05  OP(Level 1)  OP (Level 2)

Residential (Level 3) Group:  Bend  Redmond  Prineville  King City

Parent /Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Yr There: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone # \_\_\_\_\_ SSN: \_\_\_\_\_

Rent Or Own Home: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Yr There: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Current Salary: \_\_\_\_\_ Other Income: \_\_\_\_\_

Monthly Household Income: \_\_\_\_\_ Number in Household: \_\_\_\_\_

Parent /Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Yr There: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone # \_\_\_\_\_ SSN: \_\_\_\_\_

Rent Or Own Home: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Yr There: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Current Salary: \_\_\_\_\_ Other Income: \_\_\_\_\_

EMERGENCY CONTACT(Other than parent) : \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP TO CLIENT: \_\_\_\_\_

REFERRAL SOURCE: NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PROBATION OFFICER: \_\_\_\_\_ PHONE: \_\_\_\_\_

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**PRIMARY CARE DOCTOR:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**Medical Concerns:**

\_\_\_\_\_

## INSURANCE INFORMATION:

**Name of company** \_\_\_\_\_

**PLAN TYPE:** \_\_\_\_\_

**Customer Service Phone #** \_\_\_\_\_

**Pre-Auth Phone #** \_\_\_\_\_

**Card Holder:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

**Group #** \_\_\_\_\_

**ID#** \_\_\_\_\_

## SECONDARY INSURANCE:

**Name of company** \_\_\_\_\_

**PLAN TYPE:** \_\_\_\_\_

**Customer Service Phone #** \_\_\_\_\_

**Pre-Auth Phone #** \_\_\_\_\_

**Card Holder:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

**Group #** \_\_\_\_\_

**ID#** \_\_\_\_\_

**(Office Use Only) Other Funding Resources: Proof of Income must be determined**

**Outreach Service Fund:**  Des. Co MH  CYF  CC Co.  Flex Funding

Please submit past 3 months payroll stubs and or copy of last year's taxes – or Self Employed - last years Income report. Include copy of Insurance cards and or Current OHP card.