

Rimrock Trails Adolescent Treatment Services

www.rimrocktrailsats.com

Residential & Outpatient Main Campus: 1333 NW 9th St., Prineville, OR 97754 – (541)447-2631

Redmond Outpatient Office: 413 SW 8th St., Redmond, OR 97756 – (541)617-4771

Bend Outpatient Office: 1010 NW 14th St, Bend, OR 97701 (541)388-8459

Toll Free: 1-888-532-6237

FINANCIAL/CLIENT APPLICATION

Please complete all information

Referral Date: _____ Date of Admission: _____

CLIENT NAME _____ DOB: _____ Client # _____

SS# _____ Height: _____ Weight: _____ Tattoo's/Scar: _____

Eye: _____ Hair: _____ Grade: _____

Client cell number: _____

Person Providing Service: _____

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

Residential (Level 3) Group: Bend Redmond Prineville

Parent /Guardian Name: _____

Address: _____ Yr There: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone # _____ SSN: _____

Rent Or Own Home: _____ Driver's License # _____

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

Employer Name: _____ Phone #: _____

Address: _____ Yr There: _____

City: _____ State: _____ Zip: _____

Current Salary: _____ **Other Income:** _____

Bank: _____ **Location:** _____ Checking Saving

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:** _____

Request for: Deschutes County SE 66 Funds _____ **Cascade Youth Family RHI Funds:** _____

Rimrock Trails Adolescent Treatment Services

www.rimrocktrailsats.com

Residential & Outpatient Main Campus: 1333 NW 9th St., Prineville, OR 97754 – (541)447-2631

Redmond Outpatient Office: 413 SW 8th St., Redmond, OR 97756 – (541)617-4771

Bend Outpatient Office: 1010 NW 14th St, Bend, OR 97701 (541)388-8459

Toll Free: 1-888-532-6237

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.

I want to receive electronic billing: Yes No

If yes: Email Address: _____