INTAKE & FINANCIAL INFORMATION

CLIENT INFORMATION	Client No.	Admit Date:
Last Name: First: M.I.: Maiden: Gender: M F		
Address: City: State: Zip:		
County of Residence:		
Residential Phone: Other Number:		
Date of Birth (MM/DD/YYYY): Age: Social Security # (optional):		
Race (check all that apply): ( ) Caucasian ( )Amer. Indian/Alaskan Native ( ) African Amer. ( ) Hispanic ( ) Asian/Pacific Islander ( ) Other		
Marital Status (check one): ☐ never married ☐ married ☐ separated ☐ divorced ☐ widowed ☐ living as married		
Parent/Legal Guardian: Last Name: First: M.I.: Relationship:		

Previous Treatment Facility(ies):	Year(s):
Referral Source:	
Do you have a history of IV drug use? (check one): ☐ Yes ☐ No	
Have you ever been a victim of domestic violence? (check one): ☐ Yes ☐ No	

EDUCATION/EMPLOYMENT	
Years (*GED = 12 years; Associates Degree = 14 years, Bachelors Degree = 16 years)* _____	Occupation (most recent):
Veteran Status (check one): ☐ Yes ☐ No If *yes*, which branch and dates served:	

SLIDING FEE DISCOUNT APPLICATION	
Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.	
Monthly Income: $	Annual Income: $
How many people depend on or contribute to this income (including self)?	
Sources of Income/Benefits? (check all that apply): ☐ Wages ☐ Social Security ☐ SSDI ☐ TANF ☐ Public Assistance/Food Stamps ☐ Unemployment ☐ Military/VA ☐ Pension/Retirement ☐ Alimony/Child Support ☐ Self-Employment ☐ Workman's Compensation ☐ None/Other (see below)	
Other means of income when None/Other is indicated:	
Do you have (check all that apply): ☐ Private Behavioral Insurance? _____ ☐ Medicare? ☐ Medicaid?	
If minor, Responsible Party Name:	Phone:
Address: City: State: Zip:	

I CERTIFY that all information provided on this form is complete, true, and correct. I understand that the information which I submit concerning my annual income and family size is subject to verification. I also understand that if the information which I submit is determined to be false, I will be liable for the charges for all services provided. I understand that I am to report any change in my financial status during the effective period and further understand this does not release me from future liability if my financial condition improves. It is my responsibility to inform the reimbursement staff about changes and failure to do so could cause me to be responsible for payment of services receives.

Signature of Consumer (14 & older) _____ Signature of Parent/Guardian (if applicable) _____

Signature of Staff assisting Consumer: _____ Date _____