TRINITY COUNTY BEHAVIORAL HEALTH SERVICES

Client Financial Form

TCBHS ANASAZI

☐ AODS

Client's Name: (last) (first) (middle initial)	**Client #:**
Client's Date of Birth:	**Client's Social Security #:**
Responsible Party:	
Mailing Address:	
City/State/Zip:	
Phone:	
Relationship to Client:	
Number of dependents on income: _____	

Gross Family Income		**Monthly**	**Annual**
	Self		
	Spouse		
Misc. Income:	Family		
	Disability		
	Social Security		
	Unemployment		
	Public Assistance		
	Additional Source		
	Sub Total		
Allowable Expenses		**Monthly**	**Annual**
Court Ordered Obligations			
Child Care *(necessary for employment)*			
Dependent Support			
Medical Expenses			

_____ _____

Print Client Name Date

_____ _____

Signature of Client / Responsible Party Date

_____ _____

Signature of Witness Date

TRINITY COUNTY BEHAVIORAL HEALTH SERVICES
ALCOHOL AND OTHER DRUG SERVICES
P.O. Box 1640 ❖ Weaverville, CA 96093 ❖ (530) 623-1362

FINANCIAL RESPONSIBILITY

I, _____, understand and agree that I am financially responsible to pay an assessment fee based on a Fee Schedule.

I further understand that if I receive treatment services from Trinity County Behavioral Health, Alcohol and Other Drug Services, my charges for these services will be based on a Fee Schedule, which will be discussed with me at an Assessment Appointment with a counselor. I will provide a copy of my most recent source of income (pay stubs, etc.) for the past two (2) months at the time of my Assessment Appointment.

_____ Check here for Medi-Cal. **Drug Medi-Cal is considered payment in full for treatment services, except where share of cost is applicable.**

_____ _____
Client Signature Date

_____ _____
Server Signature Date

Name:_____

Phone # : _____

Mailing Address: _____

_____