EOAF, Inc.
Celebrating 60 years
1960 ~ Present

Eastern Oregon Alcoholism Foundation

Substance Abuse & Detoxification Services

E.O.R.C. ~ RESIDENTIAL PROGRAM APPLICATION

Please Fax Completed Application and Assessment to:
EOAF Residential Intake @ (541) 276-4189

Name: _____ **Birth Name:** _____

Gender: ☐ **Male** ☐ **Female** ☐ **Other:** _____ **D.O.B.:** _____ **Age:** _____

SS#: _____ -- _____ -- _____ **Have you ever served in the Military?** ☐ **Yes** ☐ **No** **Branch:** _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Mailing Address (if different than above):

_____

Primary Phone #: _____--_____--_____ **Message Phone:** _____--_____--_____ **Work Phone:** _____--_____--_____

Emergency Contact Name: _____ **Relationship:** _____

Primary Phone #: _____--_____--_____ ☐ **Cell** ☐ **Home** ☐ **Work** ☐ **Other** _____

Exclusion criteria for our residential program includes any criminal charge related to a sex offense.

Have you ever been convicted of a crime of sexual nature? ☐ **Yes** ☐ **No**

Have you ever been convicted of Assault? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Ethnicity:

☐ **Caucasian** ☐ **African American** ☐ **Hispanic** ☐ **Asian**
☐ **Hispanic / Latino American** ☐ **Hawaiian / Pacific Islander** ☐ **Other:** _____
☐ **American Indian / Alaska Native (Name of Tribe:** _____**)**

Marital Status:

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Living as Married**

Living Arrangement (within the last 30 days):

☐ **Alone** ☐ **Spouse or S/O** ☐ **Parents/Relatives/Adult Children** ☐ **Foster Home** ☐ **Jail/Prison**
☐ **Institution/Group Home** ☐ **Friends/Others** ☐ **Homeless/Shelter** ☐ **Refused/Unknown/Other**

Currently enrolled in school? ☐ **Yes** ☐ **No** **Highest Grade Completed:** _____

Employment Status:

☐ **Full-Time** ☐ **Part-Time** ☐ **Unemployed** ☐ **Student** ☐ **Retired Disabled** ☐ **Volunteer**
☐ **Homemaker** ☐ **Hospital Patient/Resident of Other Institutions** ☐ **Sheltered/Non-Competitive Employment**

Estimated Gross Income: _____

Source of Household Income:

☐ Wages/Salary ☐ Social Security SSI-Federal ☐ Dividends/Interest Volunteer

☐ Public Assistance/Welfare ☐ Alimony/Child Support ☐ Retirement/Pension

☐ Other ☐ None

Number of People in Household Dependent Upon Household Income: _____

Number of Above Dependents Under the Age of 18: _____

Health Insurance Information: (Please provide copy of card)

☐ OHP-Oregon Health Plan ☐ Other Public ☐ None

Name of Insurance/Health Plan: _____ **Policy/Group #:** _____

Name of Policy Holder: _____**Client ID #:** _____

Primary Referral:

Agency Name: _____

Contact Person: _____ **Phone #:** _____ -- _____ -- _____

Address: _____ **County:** _____

DHS Caseworker: _____ **Phone #:** _____ -- _____ -- _____ **County:** _____

Probation Officer: _____ **Phone #:** _____ -- _____ -- _____ **County:** _____

Other Agency Involved: _____ **Phone #:** _____ -- _____ -- _____ **County:** _____

Legal Status (check all that apply):

☐ DUI Diversion Client ☐ DUI Convicted Client ☐ Parole Probation

☐ 30-Day Civil Commitment ☐ 90-Day Civil Commitment ☐ 180-Day Civil Commitment

☐ Psychiatric Security Review Board ☐ Guardianship (Court) ☐ Guardianship (Child Welfare)

☐ Aid and Assist (ORS 161.370) ☐ Unknown ☐ None ☐ Other _____

Number of Arrests in Past 30 Days: _____ **Total Arrests:** _____

Number of DUI Arrests in Past 30 Days: _____ **Total DUI Arrests:** _____

Substance Use History:

Substance Use Within the Last 30 Days: ☐ Yes ☐ No

Positive Drug or Alcohol Test Within the Last 30 Days: ☐ Yes ☐ No

IV Drug Use: ☐ Yes ☐ No

Medication Assisted Treatment: ☐ Nicotine ☐ Alcohol ☐ Opiate ☐ Other _____

Primary Substance: _____ **Age of First Use:** _____ **Frequency of Use:** _____ **Route:** _____

Secondary Substance: _____ **Age of First Use:** _____ **Frequency of Use:** _____ **Route:** _____

Tertiary Substance: _____ **Age of First Use:** _____ **Frequency of Use:** _____ **Route:** _____

Self Help Programs (frequency of attendance):

☐ **No attendance in last 30 days** ☐ **1-3 times in last 30 days** ☐ **4-7 times in last 30 days**

☐ **8-15 times in last 30 days** ☐ **16-30 times in last 30 days** ☐ **Some attendance, frequency unknown**

☐ **Unknown**

Medical:

Is client pregnant? ☐ **Yes** ☐ **No** **Tobacco Use?** ☐ **Yes** ☐ **No**

Allergies? ☐ **Yes** ☐ **No** **Special Dietary Needs?** ☐ **Yes** ☐ **No**

Explain: _____ **Explain:** _____

Special accommodations for disabilities / physical limitations? ☐ **Yes** ☐ **No**

Primary Physician:

Name: _____

Address: _____

_____

Phone #: _____

Primary Dentist:

Name: _____

Address: _____

_____

Phone #: _____

Preferred Pharmacy:

Name: _____

Address: _____

_____

Phone #: _____

Mental Health Provider:

Name: _____

Address: _____

_____

Phone #: _____

Signature: _____ **Date:** _____