

CLIENT INFORMATION

PAYER FINANCIAL INFORMATION

1 CLIENT NAME	SS #	DMH CLIENT ID #	FAMILY REGISTRATION #
2 MAIDEN NAME	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP	SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME
3 FOSTER CARE <input type="checkbox"/> YES <input type="checkbox"/> NO	VICTIMS OF CRIME <input type="checkbox"/> YES <input type="checkbox"/> NO	VETERAN <input type="checkbox"/> YES <input type="checkbox"/> NO	WORKER'S COMP <input type="checkbox"/> YES <input type="checkbox"/> NO
		HOMELESS <input type="checkbox"/> YES <input type="checkbox"/> NO	CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO
4 PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if other than the client or responsible person)			

THIRD PARTY INFORMATION

5 MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO	ECM PLAN NAME	MEDI-CAL COUNTY CODE /AID CODE/ CIN #	HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO	SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO
6 SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE	REFERRED FOR BENEFITS ASSESSMENT <input type="checkbox"/> YES <input type="checkbox"/> NO DATE REFERRED	REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT			
7 MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE NUMBER (MBI)	LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO DATE SIGNED	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	TRICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	CHAMPVA <input type="checkbox"/> YES <input type="checkbox"/> NO	
8 HMO/PPO <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE ADVANTAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF CARRIER	SUBSCRIBER POLICY ID #	SUBSCRIBER NAME		
9 CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS				INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS SIGNATURES OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		
10 ADD'L HMO/PPO <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE ADVANTAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF CARRIER	SUBSCRIBER POLICY ID #	SUBSCRIBER NAME		
11 CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS				INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS SIGNATURES OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

12 NAME OF PAYER	RELATION TO CLIENT	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP	PAYER CDL/CAL ID/OTHER ID
13 PAYER'S ADDRESS	CITY	STATE	ZIP CODE	TEL #
14 SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER:				PAYER SS #
15 EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
16 EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
17 SPOUSE		ADDRESS (Include City, State & Zip Code)		SPOUSE'S SS #
18 SPOUSE'S EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
19 SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
20 NEAREST RELATIVE/RELATIONSHIP		ADDRESS (Include City, State & Zip Code)		TEL #

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS	22 ALLOWABLE EXPENSES	23 ADJUSTED MONTHLY INCOME
Savings \$ _____	Court ordered obligations paid monthly \$ _____	GROSS MONTHLY INCOME Self/Payer \$ _____
Checking Accounts \$ _____	Monthly childcare payments (necessary for employment) \$ _____	Spouse \$ _____
IRA, CD, Market value of stocks, bonds and mutual funds \$ _____	Monthly dependent support payments \$ _____	Other \$ _____
TOTAL LIQUID ASSETS \$ _____	Monthly medical expense payments \$ _____	TOTAL HOUSEHOLD INCOME \$ _____
Less Asset Allowance \$ _____	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____	TOTAL FROM BOX 21 + \$ _____
Net Asset Valuation \$ _____	Total Allowable Expenses \$ _____	SUBTOTAL + \$ _____
Monthly Asset Valuation (Divide Net Asset by 12) \$ _____		LESS TOTAL FROM BOX 22 - \$ _____
VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	Adjusted Monthly Income \$ _____
24 Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY	VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO
	ANNUAL CHARGE PERIOD	Payment Plan \$ _____ per month
	FROM _____ TO _____	for <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 months

OTHER

25 PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	CURRENT ANNUAL LIABILITY BALANCE
26 ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED <input type="checkbox"/> TFA (enter date client signed below) <input type="checkbox"/> Other (describe below)	
ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
27 An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER	PROVIDER NAME AND NUMBER		
28 I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON			
DATE			