Financial Obligation Agreement  
Supplement A-8

California Welfare and Institutions Code requires that a person receiving mental health services at a Los Angeles County operated or contracted facility will be responsible for the cost of those services in accordance with their ability to pay.

- Annual Liability = $0.00 based on income and/or Medi-Cal without Share of Cost.

- or -

Based on the fee schedule issued by the State of California your annual liability for the period of ______________ to ______________ will be $ ______________ or the actual cost of care, whichever is less.

You are required to notify this office immediately if there is a change in your financial situation including but not limited to a change in employment status, income, cash assistance (e.g.: SSI, SSDI, General Relief (GR), etc.), Medi-Cal or other healthcare coverage such as Medicare or private/group insurance. Failure to notify this office of any change in your financial situation could lead to client responsibility for the full cost of the care received from this program.

We have agreed to allow you to make monthly payments to pay off this debt. You have agreed to pay $ __________ per month for __________ months. Your first payment is due by __________ and thereafter on the __________ of each month. In the event your annual liability exceeds the actual cost of care you may discontinue your monthly payments once the actual cost of care has been paid in full.

Client Signature ____________________________ Date ______________

Clinic Representative ____________________________ Date ______________

Financial Screening - English  11/5/08

CONFIDENTIAL CLIENT INFORMATION
SEE WELFARE & INSTITUTIONS CODE, SECTION 5328