CLIENT ID #:_____
IS#:_____

Didi Hirsch
MENTAL HEALTH SERVICES

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