COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
REVENUE MANAGEMENT DIVISION

MH 281-A
6/08

CONFIDENTIAL CLIENT INFORMATION
SEE W & I CODE, SECTION 5328

Financial Screening Checklist

☐ New client ☐ Existing client

Client Information

Client Name________________________ DMH Client ID #________________

Social Security Number________________ Date of Birth________________

Someone from our DMH program will be contacting you if they need additional information.
How can they reach you? ____________________________________

Please circle: Home Phone Cell Phone Home Address e-mail Other__________

Marital Status ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

How does the client pay for food, shelter, & clothing?

☐Salary or Retirement ☐SSI ☐In-Kind Care ☐Disability Insurance ☐General Relief (GR)

☐Other______________ ☐Other Public Assistance________________

Who is paying for the client's care?

☐Medi-Cal
Medi-Cal number:________________

☐Medicare
Medicare number:________________

Have the client sign the Medicare Lifetime Authorization Form.

☐Self pay

☐HMO/PPO________________
Insurance member #:________________

☐Private Insurance________________
Insurance client ID #:________________

☐Other________________
Other client ID #:________________

Client Financial Information

Monthly Income	# Dependents on Income	Checking	Savings
$__________	__________	$__________	$__________

Has the client had prior mental health treatment under his/her current name?

☐No ☐Yes If yes, where was treatment received?________________

Client Signature ______________________________ Date______________
or Authorized Representative

Financial Screening Checklist (06/08)

Checklist completed by:________________________

Date completed:________________________