LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

PAYER FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1	CLIENT NAME		SS #	DMH CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE NAME

THIRD PARTY INFORMATION

3 ☐ NO THIRD PARTY PAYER

4	MEDI-CAL ☐ YES ☐ NO	MEDI-CAL COUNTY CODE /AID CODE/ CIN #		MEDI-CAL PENDING ☐ YES ☐ NO REFERRED FOR ELIGIBILITY ASSESSMENT ☐ YES ☐ NO				DATE REFERRED
5	SHARE OF COST ☐ YES ☐ NO	SOC AMT $	SSI PENDING ☐ YES ☐ NO	SSI APPLICATION DATE	IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON			
6	CALWORKS ☐ YES ☐ NO	GROW ☐ YES ☐ NO	HEALTHY FAMILIES ☐ YES ☐ NO	HEALTHY FAMILIES CIN #	AB3632 ☐ YES ☐ NO	AB3632 CONSENT FORM SIGNED ☐ YES ☐ NO		
7	MEDICARE ☐ YES ☐ NO	MEDICARE #	LIFETIME AUTHORIZATION SIGNED ☐ YES ☐ NO	MEDI-GAP ☐ YES ☐ NO	VET/ADM ☐ YES ☐ NO	CHAMPUS ☐ YES ☐ NO	HEALTHY WAY LA ☐ YES ☐ NO	HWLA MEMBER #
8	HMO/PPO ☐ YES ☐ NO	NAME OF CARRIER		GROUP/POLICY/ID #		NAME OF INSURED		
9	CARRIER ADDRESS					ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO		

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

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

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS

Savings	$_____
Checking Accounts	$_____
IRA, CD, Market value of stocks, bonds and mutual funds	$_____
TOTAL LIQUID ASSETS	$_____
Less Asset Allowance	$_____
Net Asset Valuation	$_____
Monthly Asset Valuation (Divide Net Asset by 12)	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

20 ALLOWABLE EXPENSES

Court ordered obligations paid monthly	$_____
Monthly child care payments (necessary for employment)	$_____
Monthly dependent support payments	$_____
Monthly medical expense payments	$_____
Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$_____
Total Allowable Expenses	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

21 ADJUSTED MONTHLY INCOME

Gross Monthly Family Income	
Self/Payer	$_____
Spouse	$_____
Other	$_____
TOTAL HOUSEHOLD INCOME	$_____
TOTAL FROM BOX 19	$_____ +
SUBTOTAL	$_____
LESS TOTAL FROM BOX 20	$_____ -
Adjusted Monthly Income	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

22	Number Dependent on Adjusted Monthly Income (Client included)	**ANNUAL LIABILITY**	**ANNUAL CHARGE PERIOD** FROM TO
			Payment Plan $_____ per month for 1 2 3 4 5 6 months.
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)		

OTHER

24	PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
27	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 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON		DATE	