LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

# PAYOR FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W &I Code, Section 5328

## CLIENT INFORMATION

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

## THIRD PARTY INFORMATON

3 **NO THIRD PARTY PAYOR** ☐

| # | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4 | MEDI-CAL ☐ YES ☐ NO | MEDI-CAL OUNTY CODE/AID CODE/ CLAIM # | | MEDI-CAL PENDING ☐ YES ☐ NO<br>REFERRED FOR ELIGIBILITY ☐ YES ☐ NO | | DATE REFERRED | |
| 5 | SHARE OF COST ☐ YES ☐ NO | SOC AMT $ | SSI PENDING ☐ YES ☐ NO | SSI APPLICATION DATE | IF MEDI-CAL/SSI ELIGIBILE BUT NOT REFERRED, STATE REASON | | |
| 6 | MEDI-CAL HMO ☐ YES ☐ NO | CAL WORKS ☐ YES ☐ NO | AB3632 ☐ YES ☐ NO | GROW ☐ YES ☐ NO | HEALTHY FAMILIES ☐ YES ☐ NO | HEALTHY FAMILIES CIN # | OTHER FUNDING |
| 7 | MEDICARE ☐ YES ☐ NO | MEDI-GAP ☐ YES ☐ NO | CHAMPUS ☐ YES ☐ NO | VET/ADM ☐ YES ☐ NO | PRIVATE INS ☐ YES ☐ NO | HMO ☐ YES ☐ NO | CLAIM # |
| 8 | NAME OF CARRIER | | GROUP/POLICY/ID # | | NAME OF INSURED | | |
| 9 | CARRIER ADDRESS | | | | ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO | | |

## PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)

| # | | | | | |
|---|---|---|---|---|---|
| 10 | NAME OF PAYOR | RELATION TO CLIENT | DOB | MARITAL STATUS M S D W SP | PAYOR CLD/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: ___________________ | | | | PAYOR SS # |
| 13 | EMPLOYER | POSITION | | | IF NOT EMPLOYED, DATE LAST WORKED |
| 14 | IPLOYER 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 ADDRESS (Include City, State & Zip Code) | | | | TEL # |
| 18 | NEAREST RELATIVE/RELATIONSHIP | ADDRESS (Include City, State & Zip Code) | | | TEL # |

## UMDAP LIABILITY DETERMINATION

| 19 LIQUID ASSETS | | 2 0 ALLOWABLE EXPENSES | | 21 ADJUSTED MONTHLY INCOME | |
|---|---|---|---|---|---|
| Savings | $ ________ | Court ordered obligations paid monthly | $ ________ | Gross Monthly Family Income | $ ________ |
| Checking Accounts | $ ________ | Monthly child care payments (necessary for employment) | $ ________ | Self/Payor | $ ________ |
| IRA, CD Market value of stocks, bonds and mutual funds | $ ________ | Monthly dependent support payments | $ ________ | Spouse | $ ________ |
| TOTAL LIQUID ASSETS | $ ________ | Monthly medical expense payments | $ ________ | Other | $ ________ |
| Less Asset Allowance | $ ________ | Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) | $ ________ | TOTAL | $ ________ |
| Net Asset Valuation | $ ________ | | | Add monthly asset valuation | $ ________ |
| **Monthly Asset Valuation (Divide Net Asset by 12)** | $ ________ | **Total Allowable Expenses** | $ ________ | TOTAL | $ ________ |
| | | | | Subtract total expenses | $ ________ |
| | | | | **Adjusted Monthly Income** | |
| VERIFICATION OBTAINED | ☐ YES ☐ NO | VERIFICATION OBTAINED | ☐ YES ☐ NO | VERIFICATION OBTAINED | ☐ YES ☐ NO |

| # | | | | |
|---|---|---|---|---|
| 22 | Number Dependent on Adjusted Monthly Income | **ANNUAL LIABILITY** | **ANNUAL CHARGE PERIOD** **FROM** **TO** | PAYMENT PLAN $ ________________ per month for ________________ months. |
| 23 | PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person) | | | |

## OTHER

| # | | | | |
|---|---|---|---|---|
| 24 | PRIOR MH TREATMENT (Only applicable to 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.<br>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<br>SIGNATURE OF CLIENT<br>OR RESPONSIILE PERSON DATE | | | |