FINANCIAL SCREENING MANUAL

Los Angeles County Department of Mental Health

Central Business Office

Manual for Department of Mental Health Legal Entity Contract Providers

This manual is published by the Los Angeles County Department of Mental Health (DMH) Central Business Office (CBO) and provides a standardized procedure for financial screening solely for the use of DMH's Legal Entity (LE) contract providers.

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Introduction

The California Department of Health Care Services (DHCS) mandates that clients treated in the county mental health care system are to be financially screened to determine the client's or the responsible party's ability to pay for the mental health services received. Financial screening allows the provider to identify how the client will pay for the mental health services they receive either through use of third-party benefits or by personal contribution. Financial screening also allows the provider to identify a client's potential eligibility for governmental benefits and make referrals to assist clients with establishing benefits. The Los Angeles County Department of Mental Health (LACDMH) uses the Payer Financial Information (PFI) form to obtain and record the client's financial circumstances.

The objective of the financial screening interview is to obtain complete and accurate billing information from each client payer at the time of their clinical visit. The State requires counties to apply the Uniform Method of Determining Ability to Pay (UMDAP) during financial screening, which includes a standard sliding scale fee to determine the client's liability amount. The UMDAP process provides an equitable uniform method of establishing a fixed liability for the client that does not exceed actual cost of services. The annual liability is extended to the client and their family members. As the financial operations staff conduct the financial screening interview, staff will:

- Identify the payer for services rendered
- Ensure the client understands that the UMDAP annual charge period is valid for a period of (1) year
- Ensure that the client understands their liability obligation at the beginning of their episode and/or during their new annual charge period

This Manual is a guide to conducting the financial screening interview. It covers the information collected during the initial and subsequent financial screening interviews that goes into the client's financial record. This information is also used when completing the Payer Financial Information (PFI) form, reviewing related agreements and insurance authorizations that the client may have to sign, requesting and reviewing supporting verification, and when initiating a re-evaluation.

Throughout the manual, the term client will be used interchangeably to mean the individual who received the mental health services and/or in reference to the payer who is the financially responsible person (i.e., client's spouse, parent, legal guardian, conservator, etc.) for the client.

Uniform Method of Determining Ability to Pay (UMDAP)

DHCS requires all specialty mental health providers to use the Uniform Method of Determining Ability to Pay (UMDAP) when assessing the ability of a client to personally pay, use third-party payers, or establish benefits to cover the mental health services they received. The client's annual liability amount is determined during the financial screening interview by using the UMDAP process. The annual liability is calculated based on the household size, adjusted gross income, resources, and allowable expenses. The client's annual liability applies for up to one year and covers services received by the client and their household from providers in the LACDMH system of care.

The UMDAP annual charge period is a twelve-month period that constitutes a client's fiscal year. Providers are required to re-evaluate the UMDAP annual liability amount every twelve-months. The UMDAP annual charge period and annual liability applies to the client and the client's household members. There can be only one UMDAP annual charge period regardless of the number of specialty mental health providers seen. The UMDAP annual charge period and annual liability should be honored throughout the State of California in any county where the client receives services. This is important because the annual liability determined during financial screening is the most a client is responsible to pay for services during the UMDAP annual charge period.

Once the annual charge period and annual liability are established, all subsequent providers must accept the UMDAP annual liability established by the previous provider for the remainder of the UMDAP liability period unless there is a change in circumstances.

How UMDAP Works

UMDAP benefits clients in that it limits how much a client and their household can be charged in an annual charge period. Clients shall be charged based on their ability to pay for mental health services rendered, but not more than actual cost of those services. They may continue to receive specialty mental health services even after they have reached their UMDAP annual liability and cannot be charged any more for services in that charge period.

Clients may receive mental health services from more than one legal entity during a given annual liability period. Subsequent providers must accept the UMDAP liability that was previously established by the initial provider for the remainder of the annual liability period unless there is a change in circumstances. Subsequent providers must also coordinate with prior providers regarding the client's current annual liability balance.

The UMDAP annual liability applies even when the client's services are covered by a third-party payer. After the payer processes the claim, UMDAP applies to the balance due on the claim.

EXAMPLE 1:

The client's cost of care is $1,000, the initial provider determined the annual liability is $100, and the third-party payer paid $500 for the service. From the $500 balance, the client is responsible to pay the annual liability of $100. The remaining $400 balance will be covered by other funding sources identified by the funding plan. Since the client paid the $100 annual liability for this service, the client will not be charged for any additional services for the rest of the annual liability period.

Cost of Care	$1,000
Payment by the Third-Party	-$500
Cost of Care Balance	$500
Annual Liability Payment by the Client	-$100
Funding Plan Covered This Balance	-$400
Client's Balance for this Annual Liability Period	$0
Cost of Care Balance	$0

EXAMPLE 2:

The client's cost of care is $1,000, the initial provider determined the annual liability is $100, and the third-party payer paid $950 for the service. From the $50 balance, the client is responsible to pay annual liability of $50. Since the client paid the $50 annual liability for this service, the client's balance for this annual liability period will be $50.

Cost of Care	$1,000
Payment by the Third-Party	-$950
Cost of Care Balance	$50
Annual Liability Payment by the Client	-$50
Client's Balance for this Annual Liability Period	$50
Cost of Care Balance	$0

Additional services were received during the annual liability period, the client's cost of care is $1,200 and the third-party payer paid $1,100 for the service. After the charge from prior services in the charge period, the client's annual liability balance is $50. The remaining $50 balance will be covered by other funding sources identified by the funding plan. Since the client paid the entire $100 annual liability for the two services, the client will not be charged for any additional services for the rest of the annual liability period.

Cost of Care	$1,200
Payment by the Third-Party	-$1,100
Cost of Care Balance	$100
Annual Liability Payment by the Client	-$50
Funding Plan Covered This Balance	-$50
Client's Balance for this Annual Liability Period	$0
Cost of Care Balance	$0

Financial Screening

Every effort should be made to capture billing information for all clients seen by LACDMH providers. Once it is clinically appropriate to do so, each new client must be financially screened before a clinical assessment is completed and after the admission has been completed. If it is not clinically appropriate to financially screen the client on the first visit, measures must be taken to ensure financial screening takes place during a subsequent visit. Clients should be made aware of the cost of services and understand their responsibility for cost of care prior to leaving the clinic. The PFI is used to document billing information collected during the financial screening interview for:

- New clients, at intake
- Existing clients, on an annual basis (during the annual reevaluation)
- Rescreening a client when there is a change to their financial circumstances or coverage

When introducing financial screening and UMDAP to clients, it is important to explain why the financial screening interview is being conducted and the benefits of using UMDAP during the process.

Benefits of Financial Screening

- ✓ *UMDAP is based on what the client can pay.*
- ✓ *Financial screening lets us know if the client can receive services at a reduced rate.*
- ✓ *UMDAP is good for an entire year!*
- ✓ ***Once the client/client's household has received the UMDAP amount in mental health services, there will not be a charge to the client for additional services for the rest of the UMDAP year!***

Completing the Payer Financial Information Form

Completing the Payer Financial Information Form (PFI)

A PFI form is required to be completed for every client treated in the LACDMH system of care. During the financial screening interview, the Payer Financial Information form (PFI) is used to capture:

- Client's financial information to determine a client's ability to pay
- Identify whether the client has third-party benefits to pay for services received
- Identify if the client may potentially be eligible for Medi-Cal or other governmental benefits

To help ensure that the financial screening is completed as efficiently as possible, provide the client with a checklist of any documentation that can be used as supporting verification of the information provided during the screening. Communicating what is needed prior to their scheduled appointment allows the client to gather the documentation in advance and bring it with them to the financial screening. The checklist provided in this manual includes acceptable supporting documents that will be used to verify identity, third-party billing, income, assets, and allowable expenses.

Clients have the right to refuse to provide financial information, however, if the client refuses to cooperate with the billing of third-party payers or refuses to provide any required information, the client shall be liable for the actual charges for services received. In the event that the client is willing but unable to provide adequate information to determine the UMDAP liability amount, then the client becomes responsible for the full cost of care which can be rescinded once the information is provided and the financial screening completed.

The PFI is organized into five (5) parts: Client Information, Third Party Information, Payer References, UMDAP Liability Determination, and Other. The following sections of this Manual provide detailed instructions for completing each part of the PFI. Each part of the PFI is to be completed in full. No field on the PFI should be left blank. If a field does not apply to a client, enter "N/A" in that field to indicate that the information is "not applicable."

NOTE: The text appearing in bold is the actual wording as it appears on the PFI

PFI – Part 1: CLIENT INFORMATION (Lines 1 to 4)

CLIENT INFORMATION

LINE 1

CLIENT NAME *Enter the client's first, middle, and last name as listed on the document used to establish the client's identity.*
SS # *Enter the client's Social Security Number, pseudo number (8 numbers followed by a P or Q at the end) if available, or 999-99-9999 if unknown or for undocumented clients.*
DMH CLIENT ID # *Enter the client's DMH identification number.*
FAMILY REGISTRATION # *Enter the client's IBHIS Family Registration number (Directly Operated only).*

LINE 2

MAIDEN NAME *Enter the client's maiden name, if applicable.*
DOB *Enter the client's 8-digit date of birth (MM/DD/YYYY) as listed on the document used to establish the client's identity.*
MARITAL STATUS ☐ **M** - *Married* ☐ **S** - *Single* ☐ **D** – *Divorced* ☐ **W** - *Widowed* ☐ **SP** – *Separated* *Check the applicable marital status.*
SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME *Enter the name of the client's spouse, partner, or significant other.*

LINE 3

FOSTER CARE ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client is in Foster Care*
VICTIMS OF CRIME ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client is Victims of Crime*
VETERAN ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client is a Veteran*
WORKERS COMP ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client has an open workers compensation case and currently receiving benefits.*
HOMELESS ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client has a permanent living space.*
CALWORKS ☐ **YES** ☐ **NO** ***NOTE: To be considered a CalWORKs client, the client must have been referred to the provider by Department of Public Social Services (DPSS) staff for DMH services in support of their employability.*** *Check the applicable box to indicate whether the client has been referred by DPSS to DMH for CalWORKs services.*
OTHER SPECIAL POPULATION *Enter any other special population that is required for agency tracking purposes.*

LINE 4

PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if *<u>other</u>* than the client or responsible person) *Enter the person's name (first, middle, and last name), residential address (Street address, City, State and ZIP+4 Code), and phone number of the person providing the financial information if that person is other than the client or responsible party.*

PFI – Part 2: THIRD PARTY INFORMATION (Lines 5 to 11)

Per Welfare and Institutions Code 5872, "participating counties shall collect reimbursement for services from…fees paid by private or public third-party payers." Financial operations staff must document any healthcare coverage the client has through all third-party payers. Third-party payers include payers such as Medi-Cal, Medicare, Tricare, CHAMPVA, or private insurance (HMO, PPO, Medicare Advantage Plans).

Verifying Medi-Cal eligibility will help identify any third-party coverage an individual might have in addition to Medi-Cal. Financial operations staff are to verify eligibility on the day of service to confirm third-party healthcare coverage with the client.

Additional verification is needed for those with coverage from payers other than Medi-Cal. When clients are covered by commercial or private insurance (including those who have assigned their Medicare over to a Medicare Advantage Plan as well as those enrolled in non-Medicare HMOs and PPOs), contact the insurance company for the following:

- Verify eligibility for mental health/behavioral health services
- ***Authorization to provide services***
- Confirm the subscriber policy number
- Coverage effective date
- Billing instructions including, but not limited to:
    - Where to send mental health/behavioral health claims (billing address)
    - Preferred claiming format or method (i.e., the Center for Medicare and Medicaid Services (CMS) 1500 form, electronic claim file [837P], provider portal, etc.)
    - Disciplines eligible to claim for services

While authorization from Medicare is not needed for clients covered under the original Medicare program, it is still important to verify Medicare eligibility through Noridian, the Medicare Administrative Contractor for Southern California.

THIRD PARTY INFORMATION

LINE 5

MEDI-CAL ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether client has Medi-Cal benefits*
ECM PLAN NAME *For clients enrolled in an Enhanced Care Management (ECM) Plan, enter the client's ECM Plan Name.*
MEDI-CAL COUNTY CODE/AID CODE/CIN # *Verify the client's eligibility for Medi-Cal. Enter the client's County Code, Medi-Cal Aid Code, and Medi-Cal Client Index Number (CIN).*
HEALTHY FAMILIES ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client has Healthy Families.*
SHARE OF COST ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client has a Medi-Cal share of cost (SOC).*
SOC AMT *If applicable, indicate the monthly dollar amount of the client's Medi-Cal SOC obligation. Verify Medi-Cal eligibility to obtain the client's SOC obligation and balance.*
MEDI-CAL PENDING ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client has a Medi-Cal application pending.*

LINE 6

SSI PENDING ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether a Supplemental Security Income (SSI) application is pending through the Social Security Administration (SSA).*
SSI APPLICATION DATE *Enter the date that the client's SSI application was submitted.*
REFERRED FOR BENEFITS ASSESSMENT ☐ **YES** ☐ **NO** *Check the applicable box to indicate whether the client was referred to determine potential eligibility for Medi-Cal or SSI benefits.* **DATE REFERRED** *(Enter the date when the client referred for benefit assessment)*
REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE FOR BENEFITS ASSESSMENT *Briefly describe why the client was not referred for benefits assessment if the client appeared to be eligible for Medi-Cal or SSI.*

LINE 7

MEDICARE
☐ **YES** ☐ **NO**

Check the appropriate box to indicate whether the client is covered under the original Medicare program

- *Check **YES** if the client has original Medicare.*
- *Check **NO** if the client does not have Medicare or if the client has assigned their Medicare over to a Medicare managed care plan (e.g., Medicare Part C, Medicare Advantage Plan, or Medicare Risk HMO).*

(To clarify who is eligible for treatment when Medicare benefits have been assigned to an HMO, refer to DMH Policy 801.05, Medicare Prepaid Health Care Treatment and Billing.)

MEDICARE NUMBER (MBI)

Enter the Client's Medicare Beneficiary Identifier number (MBI).

LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED
☐ **YES** ☐ **NO**

This form is used only when clients are covered by the original Medicare program.

Check the applicable box to indicate whether the client signed the Lifetime Extended Signature Authorization form:

- *Check **YES** if client has original Medicare and the Lifetime Extended Signature Authorization form was completed, signed, and dated.*
- *Check **NO** if the client does not have original Medicare or has assigned their Medicare over to a Medicare managed care, (i.e., Medicare Part C, Medicare Advantage Plan, Medicare Risk HMO).*

DATE SIGNED *(Enter the date when the client signed the Lifetime Extended Signature Authorization form)*

MEDI-GAP
☐ **YES** ☐ **NO**

Check the applicable box to indicate whether the client is covered by Medi-Gap insurance.

TRICARE
☐ **YES** ☐ **NO**

Check the applicable box to indicate whether the client is covered by TRICARE.

CHAMPVA
☐ **YES** ☐ **NO**

Check the applicable box to indicate whether the client is covered by CHAMPVA.

LINE 8

HMO/PPO

☐ **YES** ☐ **NO**

Check the applicable box to indicate whether the client is covered by private insurance (i.e., HMO/PPO):

- *Check **YES** if the client is covered by private insurance through a managed care plan – HMO or PPO.*
- *Check **NO** if the client is not enrolled in an HMO or PPO.*

(To clarify who is eligible for treatment, refer to DMH Policy 801.06, Private Prepaid Health Care Treatment and Billing.)

MEDICARE ADVANTAGE

☐ **YES** ☐ **NO**

Check the applicable box to indicate whether the HMO or PPO in which the client is enrolled is a Medicare Advantage Plan.

NAME OF CARRIER

Enter the name of the insurance policy carrier.

SUBSCRIBER POLICY ID #

Enter the insurance policy number (i.e., Member ID #, which can be obtained from the client's insurance card).

SUBSCRIBER NAME

Enter the name of the insured or subscriber.

LINE 9

CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS

Enter the address of where to send mental health/behavioral health claims. This address should be obtained when calling the insurance company for verify coverage, authorization to provide services, and billing instructions.

INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED

☐ **YES** ☐ **NO**

*Check **YES** if the client covered by private insurance (including Medicare Advantage Plans) and the Insurance Authorization and the Assignment of Benefits form was signed and dated.*

LINE 10

ADD'L HMO/PPO

☐ **YES** ☐ **NO**

Check the applicable box to indicate whether the client is covered by private insurance (i.e., HMO/PPO):

- *Check **YES** if the client is covered by private insurance through an additional managed care plan – HMO or PPO.*
- *Check **NO** if the client is not enrolled in an HMO or PPO.*

(To clarify who is eligible for treatment, refer to DMH Policy 801.06, Private Prepaid Health Care Treatment and Billing.)

MEDICARE ADVANTAGE

☐ **YES** ☐ **NO**

Check the applicable box to indicate whether the HMO or PPO in which the client is enrolled is a Medicare Advantage Plan.

NAME OF CARRIER

Enter the name of the insurance policy carrier.

SUBSCRIBER POLICY ID #

Enter the insurance policy number (aka Member ID #, Client ID #, or Medical Record #, this information can be obtained from the client's insurance card).

SUBSCRIBER NAME

Enter the name of the insured or subscriber.

LINE 11

CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS

Enter the address of where to send mental health/behavioral health claims. This address should be obtained when calling the insurance company for verify coverage, authorization to provide services, and billing instructions.

INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED

☐ **YES** ☐ **NO**

*Check **YES** if the client is covered by private insurance (including Medicare Advantage Plans) and the Insurance Authorization and Assignment of Benefits form was signed and dated.*

PFI – Part 3: PAYER REFERENCES [CLIENT OR FINANCIALLY RESPONSIBLE PERSON] (Lines 12 to 20)

UMDAP was developed to establish a statewide method of determining the ability of the client or financially responsible person to personally contribute to covering the cost of specialty mental health services received. A financially responsible person can be the client themselves, the client's spouse, parent, legal guardian, or conservator. In this part of the PFI, the goal is to identify who the financially responsible person (payer) is and their source of income. In general, the identified payer will be responsible for paying the client's mental health services received.

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

LINE 12

NAME OF PAYER *Enter the client or financially responsible party's first, middle, and last name.*
RELATION TO CLIENT *Enter the financially responsible party's relationship to client.*
DOB *Enter the payer's 8-digit date of birth (MM/DD/YYYY) as listed on the document used to establish identity.*
MARITAL STATUS ☐ **M** - *Married* ☐ **S** - *Single* ☐ **D** – *Divorced* ☐ **W** - *Widowed* ☐ **SP** – *Separated* *Check the applicable marital status for the financially responsible person*
PAYER CDL/CAL ID/OTHER ID *Enter the identification number from the client/financially responsible party's California Driver's License, California Identification card, or any other ID provided by the client or financially responsible party. Note the type of identification if other than a California Driver's License or California Identification card.*

LINE 13

PAYER'S ADDRESS *Enter the payer's residential street address.*
CITY *Enter the payer's city.*
STATE *Enter the payer's state.*
ZIP CODE *Enter the payer's ZIP code including the 4-digit extension (+4).*
TEL # *Enter the area code and 7-digit telephone number of the responsible party.*

LINE 14

SOURCE OF INCOME: ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐OTHER: _____
(*Check the applicable box to indicate identify how the payer/s is financially supported)*
PAYER SS #
Enter the payer's Social Security Number if the payer is someone other than the client.

LINE 15

EMPLOYER
Enter the name of the payer's employer.
POSITION
Enter the payer's payroll title or occupational position.
IF NOT EMPLOYED, DATE LAST WORKED
If the payer is not employed, enter the date last worked.

LINE 16

EMPLOYER'S ADDRESS (Include City, State & ZIP Code)
Enter the payer employer's address, include the street address, city, state, and ZIP+4 code.
TEL #
Enter the area code and 7-digit telephone number of the payer's employer.

LINE 17

SPOUSE
Enter the name of the payer's spouse.
ADDRESS (Include City, State & ZIP Code)
If different from the payer's address; enter the payer spouse's residential street address, city, state, and ZIP+4 code. If the address is the same indicate "Same as the Payer"
SPOUSE'S SS #
Enter the payer spouse's Social Security Number.

LINE 18

SPOUSE'S EMPLOYER
Enter the name of the payer spouse's employer.
POSITION
Enter the payroll title or occupation of the payer's spouse.
IF NOT EMPLOYED, DATE LAST WORKED
If the payer's spouse is not employed, enter the date they last worked.

LINE 19

SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & ZIP Code)
Enter the street address, city, state, and ZIP+4 code of the payer spouse's employer.
TEL #
Enter the area code and 7-digit telephone number of the payer's spouse's employer.

LINE 20

NEAREST RELATIVE/RELATIONSHIP *Enter the name of the client's nearest relative. State the person's relationship to the client if this person is different from the payer.*
ADDRESS (Include City, State & ZIP Code) *Enter the residential street address, city, state, and ZIP+4 code of the client's nearest relative, if different from the payer.*
TEL # *Enter the area code and 7-digit telephone number of the client's nearest relative, if this person is different from the payer.*

PFI – Part 4: UMDAP LIABILITY DETERMINATION (Boxes 21 to 23 and Line 24)

On this part of the PFI, financial operations staff will identify the income, liquid assets, and allowable expenses of the client or client's household. This information will be used as the basis to determine the client's ability to pay. This ability to pay is the client's annual liability. The annual liability amount is based on the number of people living off the gross income of the household plus assets that can be readily converted to cash less an allowance for certain types of expenses. The annual liability determined through this UMDAP process applies to the client and to all members of their family/household for a period of 365/366 days (one year).

Clients determined to be able to contribute toward the cost of the services they receive will have an annual liability. They should be informed of their responsibility at the time of determination, that all or a portion of the liability will not be due until they receive service, and that they may pay their annual liability on a payment plan.

Because the information entered into this part of the PFI is used to determine how much clients will have to pay out of pocket for services for the year, the information reported must be verified. If the client states that they have income, liquid assets, and/or allowable expenses, then the client must provide something indicating that what they stated is true and correct.

To determine the client's UMDAP annual liability, staff conducting the financial screening interview must calculate the adjusted monthly income for the client/client's household, which, in turn, is used in relation to their family/household size to find where the client falls on the UMDAP sliding fee scale. There are three elements to calculating the adjusted monthly income: Liquid Assets, Allowable Expenses, and Adjusted Monthly Income. This part of the PFI has a box dedicated to each of these elements.

Some clients are eligible for a $0 annual liability automatically. The following clients are eligible for $0 annual liability:

- Clients with full-scope Medi-Cal with no share of cost (SOC)
- Supplemental Security Income (SSI) recipients
- Clients referred by DPSS to DMH for CalWORKs services
- General Relief (GR) participants and those participating in GROW
- Clients who are homeless
- Clients in foster care or wards of the court/County/State

For the clients listed above, write "0" on each line of Boxes 21 – 23 of the PFI.

NOTE: If the annual liability is determined to be zero ($0) and the client does not have Medi-Cal, then the client meets the Medi-Cal income eligibility requirement and should be referred for a Benefits Assessment and must apply for Medi-Cal.

UMDAP Liability Determination

Liquid Assets

Liquid assets are possessions that can be easily converted into cash (such as savings accounts, checking accounts, trust funds, stocks, bonds, mutual funds, deferred compensation plans, etc.). Personal property such as a home or a vehicle are not considered liquid assets.

BOX 21 LIQUID ASSETS

Savings *Enter the amount the payer and payer's spouse have in Savings.*
Checking Accounts *Enter the amount the payer and payer's spouse have in Checking Accounts.*
IRA, CD, Market value of stocks, bonds, and mutual funds *Enter the amount the payer and payer's spouse have in their IRA, CD, market value of stocks, bonds, and mutual funds.*
TOTAL LIQUID ASSETS *Enter the combined total liquid assets for the payer and payer's spouse.*
Less Asset Allowance *Enter the Asset Allowance amount. The Asset Allowance is the dollar amount of the liquid assets a family is allowed to retain without it being added into their income for purposes of determining their annual liability. The Asset Allowance can be determined by using the chart found in the Appendix of this Financial Screening Manual.*
Net Asset Valuation *Enter the difference between the Total Liquid Asset amount less the Asset Allowance amount. Enter 0 if the Asset Allowance is greater than the Total Liquid Assets.*
Monthly Asset Valuation (Divide Net Asset by 12) *Enter the amount determined by dividing the Net Asset Valuation amount by 12. Enter 0 if the Asset Allowance is greater than the Total Liquid Assets or if the Net Asset Valuation is 0. The amount entered here is the carried forward to Box 23 – "TOTAL FROM BOX 21."*
VERIFICATION OBTAINED **☐ YES ☐ NO** *Providers are to ask for verification to validate any financial statement made by the payer. Check the applicable box to indicate whether the payer provided supporting verification of assets.*

Allowable Expenses

There are five types of allowable expenses: court ordered obligations paid monthly, monthly childcare payments, monthly dependent support payments, monthly medical expense payments, and monthly mandated deductions from gross income for retirement plans.

BOX 22 ALLOWABLE EXEPENSES

Court ordered obligations monthly *Monthly obligations include court ordered child support and alimony obligations that are to be verified with a copy of the certified court order and receipts or cancelled checks verifying payment*.
Monthly childcare payments (necessary for employment) *Payments for childcare verified with receipts or cancelled checks.*
Monthly dependent support payments *Payments can be to a client's children, spouse, or parents. The deduction is not allowed when the same person or persons are claimed as UMDAP dependents. Payments are to be verified with receipts or cancelled checks.*
Monthly medical expense payments *Includes all health, medical, and dental premiums. Also includes regular monthly medical expenses such as prescription medications and regular monthly payments and such as installments on a hospital or dental bill. Payments are to be verified with invoices, receipts, or cancelled checks.*
Monthly mandated deductions from gross income for retirement plans (Do not include Social Security) *These are payments for a retirement plan that are required as a condition of employment and are not elective. Verify deductions by obtaining a copy of a pay stub.* *NOTE: Do not include Social Security payments (listed as FICA [Federal Insurance Contribution Act] on paystubs). These payments have already been considered in determining the sliding fee schedule*
Total Allowable Expenses *Add the monthly allowable expenses together and enter the total allowable expense amount. The amount entered here is carried forward to Box 23 to the "LESS TOTAL FROM BOX 22" field.*
VERIFICATION OBTAINED **☐ YES ☐ NO** *Providers are to ask for verification to validate any financial statement made by the payer. Check the applicable box to indicate whether the payer provided supporting verification of allowable expenses .*

Adjusted Monthly Income

The gross income of household members from employment plus income from support payments, rentals, dividends, interest, etc. is totaled and used as the basis for calculating the Adjusted Monthly Income. The Adjusted Monthly Income is the total gross income for the household plus the total value of liquid assets (from Box 21) less the total of all allowable expenses (from Box 22).

BOX 23 ADJUSTED MONTHLY INCOME

GROSS MONTHLY INCOME **Self/Payer** *Enter the payer's gross monthly income from all sources of employment/self-employment.*
Spouse *Enter the payer's spouse's gross monthly income from all sources of employment/ self-employment.*
Other *Enter any additional monthly income from sources such as child/spousal support payments, rentals, dividends, interest, etc.*
TOTAL HOUSEHOLD INCOME *Enter the total gross income from the payer, the payer's spouse, and other sources of income.*
TOTAL FROM BOX 21 *Enter the "Monthly Asset Valuation" amount from BOX 21.*
SUBTOTAL *Add the Total Household Income to the Monthly Asset Valuation amount. Enter the total of the Total Household Income and the Monthly Asset Valuation.*
LESS TOTAL FROM BOX 22 *Enter the "Total Allowable Expenses" amount from BOX 22.*
Adjusted Monthly Income *Calculate the Adjusted Monthly Income by adding the Total Household Income from above and the Monthly Asset Valuation from Box 21, then subtracting the Total Allowable Expenses from Box 22.* *Total household income* *(+) Total from Box 21* *(-) Total from Box 22* *Adjusted Monthly Income*
VERIFICATION OBTAINED ☐ **YES** ☐ **NO** *Providers are to ask for verification to validate any financial statement made by the payer. Check the applicable box to indicate whether the payer provided supporting verification of stated income.*

Annual Liability & Charge Period

The annual liability is the amount the client is able to contribute to paying for services. It is based on a sliding fee scale that considers the adjusted monthly income in relation to the number of people dependent on that income. The annual charge period is the 365/366 day period in which the annual liability determined by the UMDAP process applies. Regardless of how many services the client receives during the annual charge period, the client cannot be charged any more than that annual liability for all services they receive.

LINE 24

Number Dependent on Adjusted Monthly Income (Client included) *Enter the number of people, including the client, dependent on the adjusted monthly income for over 50% support.*
ANNUAL LIABILITY *Enter the annual liability amount from the Uniform Patient Fee Schedule. Locate the annual liability amount on the Uniform Patient Fee Schedule by finding the adjusted monthly income and the number dependent on the adjusted monthly income. The Uniform Patient Fee Schedule is included in the Appendix*
ANNUAL CHARGE PERIOD **FROM _____ TO _____** *The annual charge period, also known as the annual liability period, is the timeframe in which the annual liability applies. The annual charge period lasts for 365/366 days beginning with the date of the client's first visit or billable service received in the DMH system of care. This is true regardless of when the PFI was completed or adjusted. For example, a client was admitted for services in the LACDMH system of care October 22, 2020. Since this is the client's first visit to any provider in the LACDMH system of care, then the annual charge period would be 10/22/2020 through 10/21/2021. The beginning date of the annual charge period (the UMDAP date) will remain the same even when the client has been inactive for a couple of years and returns for services on a different day. In this example, when the inactive client whose initial UMDAP date was October 22, 2020 returns for services on December 15, 2022, the UMDAP date will remain the same and the annual charge period will be 10/22/2022 through 10/21/2023.*
Payment Plan $ _____ per month **for ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 months** *Payment plans are to be established when the annual liability is determined. Enter the agreed upon amount and number of months of the payment plan. Generally, these plans should not exceed four months, but in some cases, with sufficient justification, the payment plan can be extended to six months.*

PFI – Part 5: OTHER (Lines 25 to 28)

The objective of this section of the PFI is to identify whether the client has received mental health treatment with any other DMH directly operated or contracted providers during the current annual charge period. Adjustments to the originally determined annual liability and the reason for the adjustment(s) are documented here. This section is also where staff completing the financial screening interview indicate that they have explained the UMDAP process and the outcome of the financial screening to the client and collect the client's signature.

Other

Documenting whether the client has received services from other providers during the current annual charge period helps confirm the correct dates for the charge period (all subsequent providers must accept the previously established annual charge period). Documenting the remaining annual liability balance helps prevent the client from being overcharged (all subsequent providers must accept the annual liability that was established by the initial provider for the remainder of the annual charge period).

LINE 25

PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD **☐ YES ☐ NO WHERE:** *Check **YES** if the client received mental health services from another provider during the current annual charge period. Write the name of the location where the client received services.*
FROM *Enter the date the client first received mental health services during the current annual charge period.*
TO *Enter the last date the client received mental health services during the current annual charge period.*
CURRENT ANNUAL LIABILITY BALANCE *Enter the dollar amount of any outstanding annual liability balance. Subsequent providers may collect any annual liability balance not yet incurred for services at the previous provider. Knowing the remaining annual liability balance reduces the chance of charging the client more than their established liability for the charge period. Providers may request information regarding the remaining balance of a client's annual liability by completing a **Request for Annual Liability Balance Form** included in the Appendix.*

Once established, the annual liability can be adjusted either because of a change in the client's financial circumstances or insurance coverage or for therapeutic reasons. The new annual liability amount must be documented in this section along with the reason for the adjustment.

LINE 26

ANNUAL LIABILITY ADJUSTED BY *Enter the name of the person requesting the change of the annual liability amount or payment plan during the annual charge period.*
DATE *Enter the date the adjustment was made.*
ANNUAL LIABILITY ADJUSTMENT APPROVED BY *Enter the name of the person who approved the change in the change in annual liability amount or payment plan.* *****Program Head approval is required for TFAs *****
DATE *Enter the date the adjustment was approved. If the adjustment was for therapeutic reasons, enter the date the TFA was approved by the Program Head.*
REASON ADJUSTED ☐ TFA (enter date client signed below) **☐ Other (describe below)** *Enter the reason the adjustment in the annual liability amount was made. Any verification or documentation supporting that change must be kept in the client's financial folder.*

Therapeutic Fee Adjustment (TFA)

In addition to adjustments needed because of a change in the client's financial circumstances or insurance coverage, the only other justifiable rationale for adjusting the annual liability is for therapeutic reasons. DMH Policy 804.03, Procedure A states, "When, in the opinion of the therapist, a client's treatment would benefit by an increase or decrease in the annual liability, a therapeutic adjustment is indicated." Clients who are responsible for the full cost of care do not have an annual liability and are not eligible to have their responsibility adjusted for therapeutic reasons. Program Managers or higher-level manager must approve TFAs. Once approved, the adjustment must be documented on the PFI as well as the name of the practitioner requesting the adjustment, the approving Program Manager or higher-level manager, and a brief overview explaining the reason for the adjustment.

TFAs are subject to the following limitations:

- Available only when clients have an annual liability. Clients responsible for the full cost of care are not eligible to have that responsibility adjusted for therapeutic reasons.
- Applicable to the current annual charge period only.
- TFAs cannot be applied retroactively.
    - Service costs incurred against the annual liability prior to the date of the TFA request cannot be adjusted.

Signatures on the PFI are acknowledgments of the financial screening process. Both the client/responsible party and the staff conducting the financial screening are required to sign the PFI.

LINE 27

An explanation of the UMDAP liability was provided.
SIGNATURE OF INTERVIEWER

Provider staff who conducted the financial screening signs the form. This signature acknowledges that an explanation of UMDAP liability has been provided and that there was an attempt to ensure that the client has a reasonable understanding of what the annual liability responsibility is and the client agrees to the payment plan, if applicable.

PROVIDER NAME AND NUMBER

Enter the Medi-Cal provider number and name of the service location where the financial screening was conducted.

LINE 28

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 24
SIGNATURE OF THE CLIENT OR FINANCIALLY RESPONSIBLE PERSON

The client/financially responsible person must be asked to sign as affirmation that the statements made are true and correct. Conservators do not have to sign the PFI.

DATE

The client must enter the date they are signing the PFI. Use the current date. Do not back-date or use a future date.

NOTE: REFUSING TO SIGN THE FORM IS NOT THE SAME AS REFUSING TO PROVIDE FINANCIAL INFORMATION. IF THE CLIENT PROVIDES FINANCIAL INFORMATION THAT ALLOWS COMPLETION OF THE PFI BUT REFUSES OR IS UNABLE TO SIGN THE PFI, DO NOT PLACE THE CLIENT ON FULL COST OF CARE AND ATTEMPT TO OBTAIN THE SIGNATURE AT A LATER DATE.

Sample PFIs

Completing the PFI for Special Client Populations

Providers are required to complete the PFI form for all clients during the financial screening interview. Each part of the PFI must be completed in full. Having information in every field is an indication that each question was addressed with the client. While no field should be left blank, not all information has to be collected for all clients. This chapter details completing the PFI for clients in special populations and with different types of coverage. Below are sample PFIs for clients in different coverage scenarios.

- Full scope Medi-Cal with no share of cost
- Homeless
- Foster Care
- CalWORKs
- GROW
- Full Cost of Care

Collect all financial information and complete the PFI in full for clients in special populations and with coverage scenarios not listed above.

Full Scope Medi-Cal with no Share of Cost

Full scope Medi-Cal benefits generally cover medical, dental, mental health, vision care, prescription drugs, emergency services, alcohol and other drug treatment, and more. Full scope Medi-Cal beneficiaries with no share of cost (SOC) are eligible to receive the full array of Medi-Cal services at no cost.

The annual liability for clients who have full-scope Medi-Cal with no share of cost is $0 automatically. Because the annual liability for these clients is always $0, providers are not required to collect information regarding income, assets, and allowable expenses during financial screening. The same is not true for clients who have Medi-Cal with a share of cost. Clients identified as being Medi-Cal eligible only after meeting their Medi-Cal share of cost are technically not eligible for Medi-Cal. They must interface with the UMDAP process, provide information about their income, assets, and allowable expenses, and have an annual liability determined.

If it is determined that the client has coverage from third-party payers in addition to Medi-Cal (such as Medicare or private insurance), billing information for that payer must be collected and added to the PFI. Medi-Cal is the payer of last resort and other payers must be billed before Medi-Cal. For more on collecting/adding billing information to the PFI, follow the instructions in the Third Party Information section of the previous chapter.

Providers must complete the following fields on PFIs for full scope Medi-Cal clients. No part of the PFI can be left blank. When completing the PFI for full scope Medi-Cal clients with no share of cost, enter "N/A" in those fields to indicate that the information is "not applicable." Enter "0" in the UMDAP section, Boxes 21 – 23 of the PFI.

LINE 1

Client Name
SS #
DMH Client ID #
Family Registration #

LINE 2

Maiden Name
DOB
Marital Status
Spouse/Partner/Significant Other's Name

LINE 5

MEDI-CAL **☐ YES ☐ NO**
MEDI-CAL COUNTY CODE/AID CODE/CIN #

LINE 24

Number Dependent on Adjusted Monthly Income (Client included)
ANNUAL LIABILITY *The annual liability will always be zero for full-scope Medi-Cal clients with no share of cost (SOC).*
ANNUAL CHARGE PERIOD **FROM _____ TO _____**

LINE 25

PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD **☐ YES ☐ NO WHERE:**
FROM
TO
CURRENT ANNUAL LIABILITY BALANCE

LINE 27

An explanation of the UMDAP liability was provided. **SIGNATURE OF INTERVIEWER**
PROVIDER NAME AND NUMBER

LINE 28

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 24 **SIGNATURE OF THE CLIENT** **OR FINANCIALLY RESPONSIBLE PERSON DATE**

Sample PFI for Full Scope Medi-Cal with No Share of Cost

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 #	FAMILY REGISTRATION #
2	MAIDEN NAME		DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME	
3	FOSTER CARE ☐ YES ☒ NO	VICTIMS OF CRIME ☐ YES ☒ NO	VETERAN ☐ YES ☒ NO	WORKER'S COMP ☐ YES ☒ NO	HOMELESS ☐ YES ☒ NO	CALWORKS ☐ YES ☒ NO	OTHER SPECIAL POPULATION: N/A
4	PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if *other* than the client or responsible person) N/A					

THIRD PARTY INFORMATION

5	MEDI-CAL ☒ YES ☐ NO	ECM PLAN NAME N/A	MEDI-CAL COUNTY CODE /AID CODE/ CIN #	HEALTHY FAMILIES ☐ YES ☒ NO	SHARE OF COST ☐ YES ☒ NO	SOC AMT $ N/A	MEDI-CAL PENDING ☐ YES ☒ NO
6	SSI PENDING ☐ YES ☒ NO	SSI APPLICATION DATE N/A	REFERRED FOR BENEFITS ASSESSMENT ☐ YES ☒ NO DATE REFERRED	REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT N/A			
7	MEDICARE ☐ YES ☒ NO	MEDICARE NUMBER (MBI) N/A	LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐ YES ☒ NO DATE SIGNED	MEDI-GAP ☐ YES ☒ NO	TRICARE ☐ YES ☒ NO	CHAMPVA ☐ YES ☒ NO	
8	HMO/PPO ☐ YES ☒ NO	MEDICARE ADVANTAGE ☐ YES ☒ NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A		
9	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☒ NO			
10	ADD'L HMO/PPO ☐ YES ☒ NO	MEDICARE ADVANTAGE ☐ YES ☒ NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A		
11	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☐ NO			

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

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

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS		22 ALLOWABLE EXPENSES		23 ADJUSTED MONTHLY INCOME	
Savings	$0.00	Court ordered obligations paid monthly	$0.00	GROSS MONTHLY INCOME Self/Payer	$0.00
Checking Accounts	$0.00	Monthly childcare payments (necessary for employment)	$0.00	Spouse	$0.00
IRA, CD, Market value of stocks, bonds and mutual funds	$0.00	Monthly dependent support payments	$0.00	Other	$0.00
TOTAL LIQUID ASSETS	$0.00	Monthly medical expense payments	$0.00	TOTAL HOUSEHOLD INCOME	$0.00
Less Asset Allowance	$0.00	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$0.00	TOTAL FROM BOX 21 +	$0.00
Net Asset Valuation	$0.00	**Total Allowable Expenses**	$0.00	SUBTOTAL +	$0.00
Monthly Asset Valuation (Divide Net Asset by 12)	$0.00			LESS TOTAL FROM BOX 22 -	$0.00
				Adjusted Monthly Income	$0.00
VERIFICATION OBTAINED ☐ YES ☒ NO		VERIFICATION OBTAINED ☐ YES ☒ NO		VERIFICATION OBTAINED ☐ YES ☒ NO	

24	Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD FROM _____ TO _____	Payment Plan $ 0.00 per month for ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 months

OTHER

25	PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:	FROM	TO	CURRENT ANNUAL LIABILITY BALANCE
26	ANNUAL LIABILITY ADJUSTED BY N/A	DATE N/A	REASON ADJUSTED ☐ TFA (enter date client signed below) ☐ Other (describe below) N/A	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY N/A	DATE N/A		
27	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
28	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 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON		DATE	

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

Sample PFI for full scope Medi-Cal with no share of cost, no other payers.

Homeless

Clients who are unhoused or considered homeless may or may not have access to resources such as Medi-Cal or income from a part time job. For those who do have access to resources, complete the PFI as it would be completed for clients with similar insurance coverage or who are in similar financial circumstances and indicate that the client is homeless in the Payer References part of the PFI (Lines 12-20). For those who do not have such resources, the annual liability is $0.

Complete the following fields on PFIs for homeless clients who do not have Medi-Cal or other insurance coverage. No part of the PFI can be left blank. When completing the PFI for these clients, enter "N/A" in those fields to indicate that the information is "not applicable." Enter "0" in the UMDAP section, Boxes 21 – 23 of the PFI.

LINE 1

Client Name
SS #
DMH Client ID #
Family Registration #

LINE 2

Maiden Name
DOB
Marital Status
Spouse/Partner/Significant Other's Name

LINE 12

NAME OF PAYER
RELATION TO CLIENT
DOB
MARITAL STATUS **☐ M ☐ S ☐ D ☐ W ☐ SP**
PAYER CDL/CAL ID/OTHER ID

LINE 13

PAYER'S ADDRESS *Enter the mailing address where the client receives mail, such as a DPSS office or the clinic's address.*
CITY
STATE
ZIP CODE
TEL #

LINE 14

SOURCE OF INCOME: ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐ OTHER: _____
PAYER SS #

LINE 24

Number Dependent on Adjusted Monthly Income (Client included)
ANNUAL LIABILITY
ANNUAL CHARGE PERIOD FROM _____ TO _____

LINE 25

PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:
FROM
TO
CURRENT ANNUAL LIABILITY BALANCE

LINE 27

An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER
PROVIDER NAME AND NUMBER

LINE 28

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 24 SIGNATURE OF THE CLIENT OR FINANCIALLY RESPONSIBLE PERSON DATE

Sample PFI for Homeless

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 #	FAMILY REGISTRATION #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME	
3	FOSTER CARE ☐ YES ☒ NO	VICTIMS OF CRIME ☐ YES ☐ NO	VETERAN ☐ YES ☒ NO	WORKER'S COMP ☐ YES ☒ NO	HOMELESS ☐ YES ☐ NO	CALWORKS ☐ YES ☒ NO	OTHER SPECIAL POPULATION: N/A
4	PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if **other** than the client or responsible person) N/A				

THIRD PARTY INFORMATION

5	MEDI-CAL ☐ YES ☐ NO	ECM PLAN NAME N/A	MEDI-CAL COUNTY CODE /AID CODE/ CIN #	HEALTHY FAMILIES ☐ YES ☒ NO	SHARE OF COST ☐ YES ☒ NO	SOC AMT $ N/A	MEDI-CAL PENDING ☐ YES ☐ NO	
6	SSI PENDING ☐ YES ☒ NO	SSI APPLICATION DATE N/A	REFERRED FOR BENEFITS ASSESSMENT ☐ YES ☒ NO DATE REFERRED N/A	REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT N/A				
7	MEDICARE ☐ YES ☒ NO	MEDICARE NUMBER (MBI) N/A	LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐ YES ☒ NO DATE SIGNED N/A	MEDI-GAP ☐ YES ☒ NO	TRICARE ☐ YES ☒ NO	CHAMPVA ☐ YES ☒ NO		
8	HMO/PPO ☐ YES ☒ NO	MEDICARE ADVANTAGE ☐ YES ☒ NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A			
9	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☒ NO				
10	ADD'L HMO/PPO ☐ YES ☒ NO	MEDICARE ADVANTAGE ☐ YES ☒ NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A			
11	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☒ NO				

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

12	NAME OF PAYER *Homeless*	RELATION TO CLIENT N/A	DOB N/A	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	PAYER CDL/CAL ID/OTHER ID N/A	
13	PAYER'S ADDRESS *Enter the address where the client receives mail - DPSS/Clinic Address*	CITY	STATE	ZIP CODE	TEL #	
14	SOURCE OF INCOME: ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐ OTHER: N/A				PAYER SS # N/A	
15	EMPLOYER N/A	POSITION N/A			IF NOT EMPLOYED, DATE LAST WORKED N/A	
16	EMPLOYER'S ADDRESS (Include City, State & Zip Code) N/A				TEL # N/A	
17	SPOUSE N/A	ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS # N/A	
18	SPOUSE'S EMPLOYER N/A	POSITION N/A			IF NOT EMPLOYED, DATE LAST WORKED N/A	
19	SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code) N/A				TEL # N/A	
20	NEAREST RELATIVE/RELATIONSHIP N/A	ADDRESS (Include City, State & Zip Code) N/A			TEL # N/A	

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS		22 ALLOWABLE EXPENSES		23 ADJUSTED MONTHLY INCOME	
Savings	$0.00	Court ordered obligations paid monthly	$0.00	GROSS MONTHLY INCOME Self/Payer	$0.00
Checking Accounts	$0.00	Monthly childcare payments (necessary for employment)	$0.00	Spouse	$0.00
IRA, CD, Market value of stocks, bonds and mutual funds	$0.00	Monthly dependent support payments	$0.00	Other	$0.00
TOTAL LIQUID ASSETS	$0.00	Monthly medical expense payments	$0.00	TOTAL HOUSEHOLD INCOME	$0.00
Less Asset Allowance	$0.00	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$0.00	TOTAL FROM BOX 21 +	$0.00
Net Asset Valuation	$0.00	**Total Allowable Expenses**	$0.00	SUBTOTAL +	$0.00
Monthly Asset Valuation (Divide Net Asset by 12)	$0.00			LESS TOTAL FROM BOX 22 -	$0.00
				Adjusted Monthly Income	$0.00
VERIFICATION OBTAINED ☐ YES ☒ NO		VERIFICATION OBTAINED ☐ YES ☒ NO		VERIFICATION OBTAINED ☐ YES ☒ NO	

24	Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD	Payment Plan $_____ per month
		0	FROM _____ TO _____	for ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ____ months

OTHER

25	PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:	FROM	TO	CURRENT ANNUAL LIABILITY BALANCE
26	ANNUAL LIABILITY ADJUSTED BY N/A	DATE N/A	REASON ADJUSTED ☐ TFA (enter date client signed below) ☐ Other (describe below) N/A	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY N/A	DATE N/A		
27	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
28	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 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON		DATE	

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

Sample PFI for Homeless with no third-party payers.

Foster Care

Generally, children and youth in the Foster Care system are granted full scope Medi-Cal with no share of cost. Some clients in the foster care system will be covered under the private insurance of one of the non-foster parents. If it is determined that a foster care client has insurance coverage in addition to Medi-Cal, billing information for that payer must be collected and added to the PFI. Medi-Cal is the payer of last resort and other payers must be billed before Medi-Cal.

Clients who are in the Foster Care system are considered "Wards of the Court." For the purposes of financial screening, foster parents are not considered the financially responsible person for the foster child. When the client has full scope Medi-Cal and no other coverage, enter *Ward of the Court* on Line 12 of the PFI and enter N/A in the remainder of the Payer References part of the PFI. In cases where the client is covered under a parent's insurance in addition to their full scope Medi-Cal, collect the subscriber information that is needed to bill the insurance and include it in the Payer References part of the PFI.

Please note that clients in foster care may experience multiple placements within a single annual charge period. The PFI does not have to be updated with each placement within the annual charge period.

Because those in the foster care system receive full-scope Medi-Cal, the annual liability for foster care clients will be $0 automatically. Collecting information regarding income, assets, and allowable expenses during financial screening is not required when foster care clients do not have insurance in addition to full scope Medi-Cal. For those who have additional insurance, complete the PFI as it would be completed for clients with private insurance. Complete the PFI for foster care clients who full scope, no share of cost Medi-Cal and no other coverage as follows:

LINE 1

Client Name
SS #
DMH Client ID #
Family Registration #

LINE 2

DOB
Marital Status
Spouse/Partner/Significant Other's Name

LINE 4

PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if *other* than the client or responsible person)

LINE 5

MEDI-CAL **☐ YES ☐ NO**
MEDI-CAL COUNTY CODE/AID CODE/CIN #

LINE 12

NAME OF PAYER *Enter "Ward of the Court"*

LINE 24

ANNUAL LIABILITY *The annual liability will generally be zero for foster care clients*
ANNUAL CHARGE PERIOD **FROM _____ TO _____**

LINE 25

PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD **☐ YES ☐ NO WHERE:**
FROM
TO
CURRENT ANNUAL LIABILITY BALANCE

LINE 28

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 24 **SIGNATURE OF THE CLIENT** **OR FINANCIALLY RESPONSIBLE PERSON DATE** *Enter "Ward of the Court."* *(The signature of the foster parent is not required because the County/State is the responsible party)*

Sample PFI for Foster Care

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 #	FAMILY REGISTRATION #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME	
3	FOSTER CARE ☒YES ☐NO	VICTIMS OF CRIME ☐YES ☒NO	VETERAN ☐YES ☒NO	WORKER'S COMP ☐YES ☒NO	HOMELESS ☐YES ☒NO	CALWORKS ☐YES ☒NO	OTHER SPECIAL POPULATION: N/A
4	PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if other than the client or responsible person)				

THIRD PARTY INFORMATION

5	MEDI-CAL ☐YES ☐NO	ECM PLAN NAME N/A	MEDI-CAL COUNTY CODE /AID CODE/ CIN #	HEALTHY FAMILIES ☐YES ☒NO	SHARE OF COST ☐YES ☒NO	SOC AMT $ N/A	MEDI-CAL PENDING ☐YES ☒NO
6	SSI PENDING ☐YES ☒NO	SSI APPLICATION DATE N/A	REFERRED FOR BENEFITS ASSESSMENT ☐YES ☐NO DATE REFERRED N/A	REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT N/A			
7	MEDICARE ☐YES ☒NO	MEDICARE NUMBER (MBI) N/A	LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐YES ☐NO DATE SIGNED N/A	MEDI-GAP ☐YES ☒NO	TRICARE ☐YES ☒NO	CHAMPVA ☐YES ☒NO
8	HMO/PPO ☐YES ☒NO	MEDICARE ADVANTAGE ☐YES ☒NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A	
9	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐YES ☒NO		
10	ADD'L HMO/PPO ☐YES ☒NO	MEDICARE ADVANTAGE ☐YES ☒NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A	
11	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐YES ☒NO		

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

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

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS		22 ALLOWABLE EXPENSES		23 ADJUSTED MONTHLY INCOME	
Savings	$0.00	Court ordered obligations paid monthly	$0.00	GROSS MONTHLY INCOME Self/Payer	$0.00
Checking Accounts	$0.00	Monthly childcare payments (necessary for employment)	$0.00	Spouse	$0.00
IRA, CD, Market value of stocks, bonds and mutual funds	$0.00	Monthly dependent support payments	$0.00	Other	$0.00
TOTAL LIQUID ASSETS	$0.00	Monthly medical expense payments	$0.00	TOTAL HOUSEHOLD INCOME	$0.00
Less Asset Allowance	$0.00	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$0.00	TOTAL FROM BOX 21 +	$0.00
Net Asset Valuation	$0.00			SUBTOTAL +	$0.00
Monthly Asset Valuation (Divide Net Asset by 12)	$0.00	**Total Allowable Expenses**	$0.00	LESS TOTAL FROM BOX 22 -	$0.00
				Adjusted Monthly Income	$0.00
VERIFICATION OBTAINED ☐YES ☒NO		VERIFICATION OBTAINED ☐YES ☒NO		VERIFICATION OBTAINED ☐YES ☒NO	

24	Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD	
	1	0	FROM _____ TO _____	Payment Plan $ N/A per month for ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 months

OTHER

25	PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐YES ☐NO WHERE:	FROM	TO	CURRENT ANNUAL LIABILITY BALANCE
26	ANNUAL LIABILITY ADJUSTED BY N/A	DATE N/A	REASON ADJUSTED ☐TFA (enter date client signed below) ☐Other (describe below) N/A	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY N/A	DATE N/A		
27	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
28	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 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON *Ward of the Court*		DATE	

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

Sample PFI for foster care client with no other third-party payers.

CalWORKs

The California Work Opportunities and Responsibility to Kids (CalWORKs) is a program administered by the Los Angeles County Department of Public Social Services (DPSS) that provides temporary financial assistance and employment-focused services to needy families who may qualify based on their income and property that are within the State limit based on the family size.

DMH provides clinical assessments and treatment services to participants in the CalWORKs program who have an emotional or mental disorder that would otherwise limit or impair their ability to become and remain employed. CalWORKs participants must have been referred to DMH by DPSS in order to be considered a CalWORKs client eligible for reimbursement for that program. The client's Medi-Cal aid code and/or their verbal report that they were sent to the program by DPSS is not sufficient. Providers should have a CalWORKs referral form from DPSS as verification before indicating that the client is CalWORKs on the PFI.

DPSS will reimburse DMH 100% of the cost of delivering CalWORKs covered services to CalWORKs clients. Non-covered services must be billed to the appropriate third-party payer. Billing information about those payers must be documented on the PFI in the event the client receives a non-CalWORKs covered service.

In all cases, the annual liability for CalWORKs clients is $0. Because the annual liability for CalWORKs clients is always $0, providers are not required to collect information regarding income, assets, and allowable expenses during financial screening. Enter "0" in the UMDAP section, Boxes 21 – 23 of the PFI.

LINE 1

Client Name
SS #
DMH Client ID #
Family Registration #

LINE 2

Maiden Name
DOB
Marital Status
Spouse/Partner/Significant Other's Name

LINE 3

CALWORKS **☐ YES ☐ NO**

LINE 24

ANNUAL LIABILITY *The annual liability will always be zero for CalWORKS clients.*
ANNUAL CHARGE PERIOD **FROM _____ TO _____**

LINE 25

PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD **☐ YES ☐ NO WHERE:**
FROM
TO
CURRENT ANNUAL LIABILITY BALANCE

LINE 28

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 24 SIGNATURE OF THE CLIENT OR FINANCIALLY RESPONSIBLE PERSON DATE

Sample PFI for CalWORKs

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 #	FAMILY REGISTRATION #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME	
3	FOSTER CARE ☐ YES ☒ NO	VICTIMS OF CRIME ☐ YES ☒ NO	VETERAN ☐ YES ☒ NO	WORKER'S COMP ☐ YES ☒ NO	HOMELESS ☐ YES ☒ NO	CALWORKS ☒ YES ☐ NO	OTHER SPECIAL POPULATION: N/A
4	PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if other than the client or responsible person) N/A						

THIRD PARTY INFORMATION

5	MEDI-CAL ☐ YES ☐ NO	ECM PLAN NAME N/A	MEDI-CAL COUNTY CODE /AID CODE/ CIN #	HEALTHY FAMILIES ☐ YES ☒ NO	SHARE OF COST ☐ YES ☒ NO	SOC AMT $	MEDI-CAL PENDING ☐ YES ☒ NO
6	SSI PENDING ☐ YES ☒ NO	SSI APPLICATION DATE N/A	REFERRED FOR BENEFITS ASSESSMENT ☐ YES ☐ NO DATE REFERRED	REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT N/A			
7	MEDICARE ☐ YES ☒ NO	MEDICARE NUMBER (MBI) N/A	LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐ YES ☐ NO DATE SIGNED N/A	MEDI-GAP ☐ YES ☒ NO	TRICARE ☐ YES ☒ NO	CHAMPVA ☐ YES ☒ NO	
8	HMO/PPO ☐ YES ☒ NO	MEDICARE ADVANTAGE ☐ YES ☒ NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A		
9	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☒ NO			
10	ADD'L HMO/PPO ☐ YES ☒ NO	MEDICARE ADVANTAGE ☐ YES ☒ NO	NAME OF CARRIER N/A	SUBSCRIBER POLICY ID # N/A	SUBSCRIBER NAME N/A		
11	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☒ NO			

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

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

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS		22 ALLOWABLE EXPENSES		23 ADJUSTED MONTHLY INCOME	
Savings	$0.00	Court ordered obligations paid monthly	$0.00	GROSS MONTHLY INCOME Self/Payer	$0.00
Checking Accounts	$0.00	Monthly childcare payments (necessary for employment)	$0.00	Spouse	$0.00
IRA, CD, Market value of stocks, bonds and mutual funds	$0.00	Monthly dependent support payments	$0.00	Other	$0.00
TOTAL LIQUID ASSETS	$0.00	Monthly medical expense payments	$0.00	TOTAL HOUSEHOLD INCOME	$0.00
Less Asset Allowance	$0.00	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$0.00	TOTAL FROM BOX 21 +	$0.00
Net Asset Valuation	$0.00	**Total Allowable Expenses**	$0.00	SUBTOTAL +	$0.00
Monthly Asset Valuation (Divide Net Asset by 12)	$0.00			LESS TOTAL FROM BOX 22 -	$0.00
				Adjusted Monthly Income	$0.00
VERIFICATION OBTAINED ☐ YES ☒ NO		VERIFICATION OBTAINED ☐ YES ☒ NO		VERIFICATION OBTAINED ☐ YES ☒ NO	

24	Number Dependent on Adjusted Monthly Income (Client Included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD	Payment Plan
		0	FROM _____ TO _____	Payment Plan $ N/A per month for ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 months

OTHER

25	PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:	FROM	TO	CURRENT ANNUAL LIABILITY BALANCE
26	ANNUAL LIABILITY ADJUSTED BY N/A	DATE N/A	REASON ADJUSTED ☐ TFA (enter date client signed below) ☐ Other (describe below) N/A	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY N/A	DATE N/A		
27	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
28	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 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON		DATE	

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

Sample PFI for CalWORKs clients with a valid referral from DPSS.

GROW

The General Relief Opportunities for Work (GROW) is a program administered by DPSS that provides employment and training services to General Relief (GR) participants to help get a job and become self-sufficient.

DMH provides clinical assessments and treatment services to GROW participants who have an emotional or mental disorder that would otherwise limit or impair their ability to become and remain employed. In order to be considered a GROW client eligible for reimbursement, the GROW participant must have been referred to DMH by DPSS. Providers should have a referral from DPSS as verification in order to indicate that the client is considered a GROW client in the Other Special Population field of the PFI.

GROW clients may or may not have Medi-Cal. Billing information about Medi-Cal and any other payers must be documented on the PFI.

In all cases, the annual liability for GROW clients is $0. Because the annual liability for GROW clients is always $0, providers are not required to collect information regarding income, assets, and allowable expenses during financial screening. Enter "0" in the UMDAP section, Boxes 21 - 23 of the PFI.

LINE 1

Client Name
SS #
DMH Client ID #
Family Registration #

LINE 2

Maiden Name
DOB
Marital Status
Spouse/Partner/Significant Other's Name

LINE 3

Other Special Population: *Enter "GROW Client" for tracking purposes*

LINE 24

ANNUAL LIABILITY *The annual liability will always be zero for GROW clients.*
ANNUAL CHARGE PERIOD **FROM _____ TO _____**

LINE 25

PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD **☐ YES ☐ NO WHERE:**
FROM
TO
CURRENT ANNUAL LIABILITY BALANCE

LINE 28

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 24 SIGNATURE OF THE CLIENT OR FINANCIALLY RESPONSIBLE PERSON DATE

Sample PFI for GROW

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 #	FAMILY REGISTRATION #
2	MAIDEN NAME		DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME	
3	FOSTER CARE ☐YES ☒NO	VICTIMS OF CRIME ☐YES ☒NO	VETERAN ☐YES ☒NO	WORKER'S COMP ☐YES ☒NO	HOMELESS ☐YES ☒NO	CALWORKS ☐YES ☒NO	OTHER SPECIAL POPULATION: **GROW**
4	PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if other than the client or responsible person) **N/A**					

THIRD PARTY INFORMATION

5	MEDI-CAL ☐YES ☒NO	ECM PLAN NAME **N/A**	MEDI-CAL COUNTY CODE /AID CODE/ CIN # **N/A**	HEALTHY FAMILIES ☐YES ☒NO	SHARE OF COST ☐YES ☒NO	SOC AMT $ **N/A**	MEDI-CAL PENDING ☐YES ☒NO
6	SSI PENDING ☐YES ☒NO	SSI APPLICATION DATE **N/A**	REFERRED FOR BENEFITS ASSESSMENT ☐YES ☒NO DATE REFERRED **N/A**	REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT **N/A**			
7	MEDICARE ☐YES ☒NO	MEDICARE NUMBER (MBI) **N/A**	LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐YES ☒NO DATE SIGNED **N/A**	MEDI-GAP ☐YES ☒NO	TRICARE ☐YES ☒NO	CHAMPVA ☐YES ☒NO	
8	HMO/PPO ☐YES ☒NO	MEDICARE ADVANTAGE ☐YES ☒NO	NAME OF CARRIER **N/A**	SUBSCRIBER POLICY ID # **N/A**	SUBSCRIBER NAME **N/A**		
9	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS **N/A**			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐YES ☒NO			
10	ADD'L HMO/PPO ☐YES ☒NO	MEDICARE ADVANTAGE ☐YES ☒NO	NAME OF CARRIER **N/A**	SUBSCRIBER POLICY ID # **N/A**	SUBSCRIBER NAME **N/A**		
11	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS **N/A**			INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐YES ☒NO			

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

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

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS		22 ALLOWABLE EXPENSES		23 ADJUSTED MONTHLY INCOME	
Savings	$0.00	Court ordered obligations paid monthly	$0.00	GROSS MONTHLY INCOME Self/Payer	$0.00
Checking Accounts	$0.00	Monthly childcare payments (necessary for employment)	$0.00	Spouse	$0.00
IRA, CD, Market value of stocks, bonds and mutual funds	$0.00	Monthly dependent support payments	$0.00	Other	$0.00
TOTAL LIQUID ASSETS	$0.00	Monthly medical expense payments	$0.00	TOTAL HOUSEHOLD INCOME	$0.00
Less Asset Allowance	$0.00	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$0.00	TOTAL FROM BOX 21 +	$0.00
Net Asset Valuation	$0.00	**Total Allowable Expenses**	$0.00	SUBTOTAL +	$0.00
Monthly Asset Valuation (Divide Net Asset by 12)	$0.00			LESS TOTAL FROM BOX 22 -	$0.00
				Adjusted Monthly Income	$0.00
VERIFICATION OBTAINED ☐YES ☒NO		VERIFICATION OBTAINED ☐YES ☒NO		VERIFICATION OBTAINED ☐YES ☒NO	

24	Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD	
	1	0	FROM _____ TO _____	Payment Plan $ N/A per month for ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 months

OTHER

25	PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐YES ☐NO WHERE:	FROM	TO	CURRENT ANNUAL LIABILITY BALANCE
26	ANNUAL LIABILITY ADJUSTED BY **N/A**	DATE **N/A**	REASON ADJUSTED ☐TFA (enter date client signed below) ☐Other (describe below) **N/A**	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY **N/A**	DATE **N/A**		
27	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
28	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 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON		DATE	

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

Sample PFI for GROW client without Medi-Cal who has valid referral from DPSS.

Full Cost of Care

Occasionally, clients are responsible for the actual cost of services. Clients responsible for the actual cost of services, or Full Cost of Care (FCC) clients, have an annual charge period but are not on an annual liability: they must pay for services as costs are incurred.

Clients become full cost of care clients when they refuse to cooperate with the financial screening process or when authorization to bill for the services they receive has not be granted or received.

- Refusal
    - Refusing to provide information needed for billing third-party payers.
    - Refusing to allow the third-party payer to be billed.
    - Refusing to provide verification supporting the information offered during the financial screening interview.
        - It is extremely important to distinguish between refusal to provide and an inability to provide or barrier to providing the supporting information even when there is a willingness to do so. In all cases, engage the clinical team to encourage the client in bringing supporting documentation.
- Unauthorized private insurance
    - Insurance does not authorize mental health services.
        - Excludes clients who have exhausted coverage for mental health services within their plan year.
            - Clients who have exhausted the number of services allowed for their plan year are eligible for an annual liability.

Note: ***Clients eligible for full-scope Medi-Cal must not be charged for services received unless they place a restriction on billing Medi-Cal and have the understanding that they must pay the full cost of care.***

Collect all information requested and complete the PFI in full. Enter $999,999.99 for Self in Box 23. Clients designated as full cost of care cannot be placed on a payment plan and are responsible to pay for services as costs are incurred and billed.

Do not designate clients who have cooperated with the financial screening process as FCC even in cases when the annual liability is extremely high. Full cost of care clients are not eligible for an annual liability which makes them ineligible for Therapeutic Fee Adjustments if one becomes necessary. Indicate the actual gross monthly income for the client rather than $999,999.99 and the actual income of other contributors to the household then determine the actual annual liability using the sliding fee scale.

LINE 1

Client Name
SS #
DMH Client ID #
Family Registration #

LINE 2

Maiden Name
DOB
Marital Status

LINE 24

Number Dependent on Adjusted Monthly Income (Client included) **Enter the actual number of people dependent on the income.**
ANNUAL LIABILITY **Enter "FCC" to indicate Full Cost of Care.**
ANNUAL CHARGE PERIOD **FROM _____ TO _____**

LINE 25

PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD **☐ YES ☐ NO WHERE:**
FROM
TO
CURRENT ANNUAL LIABILITY BALANCE

LINE 28

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 24 **SIGNATURE OF THE CLIENT** **OR FINANCIALLY RESPONSIBLE PERSON DATE**

Sample PFI for Full Cost of Care

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 #	FAMILY REGISTRATION #
2	MAIDEN NAME		DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP		SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME	
3	FOSTER CARE ☐ YES ☐ NO	VICTIMS OF CRIME ☐ YES ☐ NO	VETERAN ☐ YES ☐ NO	WORKER'S COMP ☐ YES ☐ NO	HOMELESS ☐ YES ☐ NO	CALWORKS ☐ YES ☐ NO	OTHER SPECIAL POPULATION:
4	PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if other than the client or responsible person)						

THIRD PARTY INFORMATION

5	MEDI-CAL ☐ YES ☐ NO	ECM PLAN NAME	MEDI-CAL COUNTY CODE /AID CODE/ CIN #	HEALTHY FAMILIES ☐ YES ☐ NO	SHARE OF COST ☐ YES ☐ NO	SOC AMT $	MEDI-CAL PENDING ☐ YES ☐ NO
6	SSI PENDING ☐ YES ☐ NO	SSI APPLICATION DATE	REFERRED FOR BENEFITS ASSESSMENT ☐ YES ☐ NO DATE REFERRED	REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT			
7	MEDICARE ☐ YES ☐ NO	MEDICARE NUMBER (MBI)	LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐ YES ☐ NO DATE SIGNED	MEDI-GAP ☐ YES ☐ NO	TRICARE ☐ YES ☐ NO	CHAMPVA ☐ YES ☐ NO	
8	HMO/PPO ☐ YES ☐ NO	MEDICARE ADVANTAGE ☐ YES ☐ NO	NAME OF CARRIER	SUBSCRIBER POLICY ID #	SUBSCRIBER NAME		
9	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS				INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☐ NO		
10	ADD'L HMO/PPO ☐ YES ☐ NO	MEDICARE ADVANTAGE ☐ YES ☐ NO	NAME OF CARRIER	SUBSCRIBER POLICY ID #	SUBSCRIBER NAME		
11	CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS N/A				INSURANCE ASSIGNMENT & RELEASE SIGNATURES OBTAINED ☐ YES ☐ NO		

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

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

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS		22 ALLOWABLE EXPENSES		23 ADJUSTED MONTHLY INCOME	
Savings	$_____	Court ordered obligations paid monthly	$	GROSS MONTHLY INCOME Self/Payer	$ 999,999.99
Checking Accounts	$_____	Monthly childcare payments (necessary for employment)	$	Spouse	$_____
IRA, CD, Market value of stocks, bonds and mutual funds	$_____	Monthly dependent support payments	$_____	Other	$
TOTAL LIQUID ASSETS	$_____	Monthly medical expense payments	$_____	TOTAL HOUSEHOLD INCOME	$
Less Asset Allowance	$	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$	TOTAL FROM BOX 21	+ $_____
Net Asset Valuation	$_____			SUBTOTAL	+ $_____
Monthly Asset Valuation (Divide Net Asset by 12)	$_____	**Total Allowable Expenses**	$_____	LESS TOTAL FROM BOX 22	- $_____
				Adjusted Monthly Income	$_____
VERIFICATION OBTAINED ☐ YES ☐ NO		VERIFICATION OBTAINED ☐ YES ☐ NO		VERIFICATION OBTAINED ☐ YES ☐ NO	

24	Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY FCC	ANNUAL CHARGE PERIOD FROM _____ TO _____	Payment Plan $ N/A per month for ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 months

OTHER

25	PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:	FROM	TO	CURRENT ANNUAL LIABILITY BALANCE
26	ANNUAL LIABILITY ADJUSTED BY N/A	DATE N/A	REASON ADJUSTED ☐ TFA (enter date client signed below) ☐ Other (describe below) N/A	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY N/A	DATE N/A		
27	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
28	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 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON		DATE	

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

Sample PFI for full cost of care.

Medi-Cal

Medi-Cal

Medi-Cal is the federal Medicaid public health insurance program in California financed equally by the State and federal government funds. Medi-Cal provides coverage for needed physical and mental health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people. There are also specific Medi-Cal programs for disabled individuals with tuberculosis, breast cancer, or HIV/AIDS. This coverage is at no cost or at a low cost to individuals and/or families.

Medi-Cal is open to all residents of California, regardless of their immigration status, as long as the individual meets the eligibility requirements. Medi-Cal coverage may or may not be restricted based on the individual's immigration status. Immigration status does not impact whether the beneficiary will have a cost-sharing obligation.

Providers must verify Medi-Cal eligibility at intake and that the client presenting is the individual to whom the card was issued. Eligibility must also be verified on the date of service. Verifying Medi-Cal eligibility confirms whether the client is eligible to receive services, the scope of coverage, and whether the client has a cost sharing obligation, or share of cost. This chapter reviews:

- Verifying Medi-Cal Eligibility
- Medi-Cal Eligibility Response Messages
- Medi-Cal Managed Care Plans
- Medi-Cal Share of Cost

Verifying Medi-Cal Eligibility

Providers must check for Medi-Cal eligibility on the date of service ***for all clients***, even those not identified as Medi-Cal beneficiaries previously. The Point of Service (POS) network allows providers to access Medi-Cal eligibility information and perform share of cost spend down transactions. The eligibility response also includes information about additional coverage (insurance) the client might have. An Eligibility Verification Confirmation (EVC) number will be returned for all those who are eligible for Medi-Cal on the date of service. Keep a record of the EVC as proof of having verified eligibility for the client.

Methods for Verifying Eligibility

Verify Medi-Cal eligibility using the following methods:

- Medi-Cal website
- Real Time Inquiry (270/271)
- Automated Eligibility Verification System (AEVS)
- Point of Service (POS) Device

Medi-Cal website

www.medi-cal.ca.gov

The Medi-Cal website allows providers to obtain eligibility information on the client. Eligibility can be verified using the client's Medi-Cal Client Index Number (CIN) or Social Security Number (SSN) and date of birth. Eligibility can be verified for a single client or for a batch of up to 99 clients at one time.

Real Time Inquiry (270/271)

Real Time Eligibility Inquiries (also known as 270/271) are electronic transactions that are compliant with standards set by Health Insurance Portability and Accountability Act of 1996 (HIPAA). With this method, providers are able to send electronic eligibility inquiries (270) directly to Medi-Cal and receive a response (271) within moments. Real Time Inquiries are accessed through provider Electronic Health Records (EHR) and/or claiming systems.

Automated Eligibility Verification System (AEVS)

1 (800) 456-2387

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers the ability to verify Medi-Cal eligibility using a touch-tone phone. AEVS can also

be used to spend down a client's share of cost. Providers must have a valid Provider Identification Number (PIN) to access AEVS. Medi-Cal PINs are issued as part of the certification process. Temporary PINs are available, if needed. Document the eligibility information given by AEVS including the EVC number. Using a tracking log or form such as the AEVS Response Log makes it easier to save eligibility responses for future reference during audits.

Point of Service (POS) Device

The POS device allows providers to swipe the client's Benefit Identification Card (BIC) to obtain the client's Medi-Cal eligibility. Retain the response in the client's financial record.

Medi-Cal Eligibility Response Messages

Regardless of the method used, carefully review all information returned from the eligibility response to ensure that specialty mental health services are covered under the beneficiary's eligibility. Positive or conditional eligibility responses include the following basic information:

- County Code
- Aid Code
- Share of Cost, if applicable
- Medi-Cal Managed Care Plan information, if applicable
- EVC number (may or may not be returned on conditional eligibility responses)

County Code

The eligibility response will contain a two-digit code for the county where Medi-Cal benefits were established, or the County of Responsibility. This could be different from the client's County of Residence. The code for Los Angeles County is 19.

Aid Code

The aid code is the two-character alpha numeric code for the program under which the client is eligible for Medi-Cal. The Medi-Cal Eligibility Group, scope of coverage (restricted vs. limited vs. full scope), share of cost, and funding information are linked to the assigned aid code.

Share of Cost (SOC)

Share of cost (SOC) is the monthly deductible the beneficiary must be obligated to pay before becoming Medi-Cal eligible for the month. The eligibility response will indicate the beneficiary's monthly SOC obligation and the amount that still needs to be spent down before they can be considered Medi-Cal eligible. SOC information will not be included in the response after the client has met the monthly obligation and is eligible for Medi-Cal for that month.

Managed Care Plan information

Managed Care Plans are health plans contracted with DHCS to provide health services other than specialty mental health services to Medi-Cal beneficiaries. Managed Care Plan and Health Care Plan are used interchangeably. Eligibility responses include the plan information below:

- **PHP**: Prepaid Health Plan
- **HCP**: Health Care Provider
- **PCP**: Primary Care Physician

EVC number

This number is evidence that eligibility was verified and that the provider received a positive eligibility response. Receiving an EVC number does not guarantee claim payment.

Medi-Cal Eligibility Response Message Keywords

Medi-Cal's eligibility message not only contains information about the scope of Medi-Cal coverage, but it also includes information about other third-party payer benefits the client might be able to access to cover the cost of services. Below are keywords for different types of payers that might be seen in the Medi-Cal eligibility message:

Payer Type	Keywords	Comments
Medi-Cal	MEDI-CAL ELIGIBLE W/NO SOC SPEND DOWN	Client has full-scope Medi-Cal
	PHP (Prepaid Health Plan)	Also referred to as the Managed Care Plan (MCP). The agency contracted with the State to administer the Medi-Cal program and provide health services to the beneficiary
	HCP (Health Care Provider)	The agency contracted with the MCP provide services on their behalf
	PCP (Primary Care Physician)	The physician responsible for overseeing the beneficiary's care.
Medicare	PART A, B AND D MEDICARE COV W/MBI #0AA0-A0-AA00. MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL	Client is enrolled in the original Medicare program and has not signed their benefits over to a Medicare Advantage Plan. Outpatient services are billed under Medicare Part B and inpatient services are billed under Medicare Part A.
Private Insurance or Commercial Insurance **(*includes Medicare Advantage Plans*)**	OTHER HEALTH INSURANCE COV [Carrier Name]	Client has private insurance in addition to Medi-Cal. The insurance must approve or deny claims for this client before Medi-Cal can be billed. *Confirm coverage with the client.* *Use the contact information on the client's insurance card or the eligibility response to verify eligibility and obtain authorization to provide services.*

Payer Type	Keywords	Comments
Private Insurance or Commercial Insurance (*includes Medicare Advantage Plans*) (continued)	OTHER HEALTH INSURANCE COV UNDER CODE F, Medicare Risk HMO. MEDICARE PART C [Carrier Name]	Client has assigned their Medicare to private insurance plan. This insurance is in addition to Medi-Cal. The Medicare Advantage Plan must approve or deny Medicare billable claims for this client before Medi-Cal can be billed. *Confirm coverage with the client.* *Use the contact information on the client's insurance card or the eligibility response to verify eligibility and obtain authorization to provide services.*
	COV: OIM VD (P R) L	The codes for the types of services covered by the insurance. O: Outpatient I: Inpatient M: Medical and allied services P: Prescription drugs, medical supplies V: Vision care D: Dental services L: Long Term Care R: Medicare Part D – Prescription Drug Coverage.

Once eligibility is verified, place a copy of the eligibility response or a report of that response in the client's financial record.

Medi-Cal Managed Care Plans

Medi-Cal Managed Care contracts with established health care networks to provide health care services to Medi-Cal beneficiaries. These networks focus on primary and preventive care. Medi-Cal Managed Care Plans are Prepaid Health Plans (PHP) that help with the delivery of care provided to Medi-Cal beneficiaries. They reduce the high cost of services for the Medi-Cal program, improve access to services, and maintain continuity of medical services. Medi-Cal Managed Care Plans are not considered other health coverage (OHC) for specialty mental health services because the healthcare plan is managing Medi-Cal on behalf of the State.

Medi-Cal Managed Care Plans are not responsible for specialty mental health services. Specialty mental health services are "carved out" of the coverage offered by the PHP. Specialty mental health services are not billed to the client's PHP or the subcontracted Health Care Provider (HCP). They are provided through County Mental Health Plans (MHPs) in California's 58 counties. MHPs provide and/or arrange for specialty mental health services and bill Medi-Cal directly through Short-Doyle/Medi-Cal. The MHP for Los Angeles County is the Los Angeles County Department of Mental Health.

Below are samples of eligibility responses that will assist with identifying Medi-Cal managed Care plan in distinction from other health coverage:

Sample Medi-Cal Managed Care Eligibility Responses

Specialty Mental Health Services are CARVED OUT

DO NOT BILL ANY OF THE PLANS LISTED IN THE ELIGIBILITY RESPONSE

Sample 1: Regular Medi-Cal with MHS Carved out

SUBSCRIBER LAST NAME: Doe. EVC #: 000000ZX0. CNTY CODE: 19. PRMY AID CODE: 3N. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (123) 123-1234. HCP: ANTHEM BLUE CROSS CALL: (123) 123-1234. PCP: DR. K CALL: (123) 123-1234. ACCESS DENTAL PLAN: DENTAL CALL (123)123-1234

Sample 2: Regular Medi-Cal with MHS Carved out

SUBSCRIBER LAST NAME: XXXX. EVC #: XXXX. CNTY CODE: 19. PRMY AID CODE: 34. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (123) 123-1234. HCP: LA CARE HLTH PLAN CALL: (123) 123-1234. PCP: DR. B CALL: (123) 123-1234

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) services are an extension of Medi-Cal services offered by Medi-Cal Managed Care Plans. In order to receive ECM services, clients must have their Medi-Cal assigned to a Medi-Cal Managed Care Plan and be enrolled with that plan to receive ECM services. Clients are either enrolled by a provider contracted with the Managed Care Plan to deliver ECM services or the Plan refers the client to a provider contracting with them to deliver ECM services. Only agencies contracted with the Managed Care Plan are able to bill for ECM services. ECM services are only billable to the Plan and should not be billed to any other payer.

Medi-Cal Share of Cost (SOC)

Some Medi-Cal recipients have cost-sharing responsibilities each month before they become eligible for Medi-Cal benefits for the month. This monthly cost-sharing obligation is called Share of Cost (SOC). SOC refers to the amount of health care expenses a recipient must accumulate each month before Medi-Cal begins to cover the cost of additional services for that month. SOC is determined when Medi-Cal is granted or renewed. Refer clients with concerns about their share of cost to DPSS or the agency that granted them Medi-Cal.

For the client to meet their obligation, SOC must be cleared, or spent down to $0. SOC cannot be spent down unless a service is provided. Spend down SOC for the cost of service less the amount paid by other payers as soon as possible after the service has been rendered using the Medi-Cal website, a HIPAA 270/271 eligibility transaction, AEVS, or a POS device. The cost of service is based on the hourly rate for the practitioner rendering the service plus the rate for add-on services such as interpretation.

Once SOC is cleared, verify Medi-Cal eligibility. The EVC number in the response will confirm that the recipient is eligible for Medi-Cal. Any additional health care services in that month are billable to Medi-Cal.

The SOC spend down amount is owed to the provider. Any portion of a service used to spend down SOC cannot be billed to Medi-Cal. Providers must collect the SOC obligation from the client. UMDAP rules apply. Providers may only collect the actual cost of service, SOC dollar amount, or the annual liability amount; whichever is less. This means that clients who have Medi-Cal with a share of cost must have an UMDAP annual liability determined.

Example

Medi-Cal billed after the client's SOC obligation was met

Actual Cost of Service	$158
Client's SOC (spend down) amount obligation $75	-$75
Balance billed to Medi-Cal after the client has met their SOC obligation	$83

Client responsibility

Actual Cost of Service	$158
Annual Liability balance	$50
SOC (total amount to be spent down monthly)	$75

Client owes the Annual Liability *The Annual Liability is less than the SOC and the Cost of Service*	**$50**

Family Share of Cost

Sometimes, an individual with full scope Medi-Cal is included in a Medi-Cal case with others who have a share cost. These individuals have a Family Share of Cost. Clients with full scope Medi-Cal and a Family Share of Cost may choose to use their services to spend down the Family SOC.

Eligibility Message: SUBSCRIBER LAST NAME: DOE. EVC #: 106CIMWT8V. CNTY CODE: 19. 1ST SPECIAL AID CODE: TI. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (888)839-9909. HCP: LA CARE HLTH PLAN CALL: (888) 839-9909. PCP: MICHAEL MICHAEL CALL: (888)999-9999. SUBSCRIBER CAN ALSO CHOOSE TO APPLY MEDICAL EXPENSES TOWARDS FAMILY SOC/SPEND DOWN. REMAINING SOC/SPEND DOWN $
1393.00.

Full scope Medi-Cal beneficiaries who have a Family Share of Cost are still recipients of full scope Medi-Cal and cannot be charged for services. The annual liability for these clients is $0.

Third-Party Payers: Private Insurance and Medicare

Third-party payers are sources other than the client or responsible person, who are legally liable for all or part of the cost of patient care such as Medi-Cal, private insurance, or Medicare. It is imperative that all third-party payers are identified during financial screening interviews and billed to ensure that the benefits are maximized. When a client has insurance coverage from a third-party payer in addition to Medi-Cal, Medi-Cal will not pay for services to that individual until that payer has had the opportunity to pay for some or all of the cost of those services (Welfare & Institutions Code 10025 and 5872).

Private Insurance

Private insurance, also referred to as Commercial Insurance or Other Health Coverage (OHC), is healthcare coverage for medical services and supplies including, but are not limited to, inpatient hospital care, outpatient services, doctor/medical professional visits, dental care, vision care, and pharmacy. Private insurance companies are also responsible for providing or covering mental health services to individuals enrolled in their plans.

Private insurance plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Medicare Advantage Plans. Medi-Cal Managed Care Plans, including AltaMed/PACE, are not considered private insurance or OHC. People with private insurance must seek to obtain non-crisis mental health services from providers affiliated with the insurance network. The insurance plans must either provide the mental health services the person seeks or pay in full for those services.

Sometimes, people with private insurance would prefer to receive services from a DMH provider rather than from a provider affiliated with their insurance's network. When, in consultation with the clinical team, someone with private insurance chooses to receive services from a contracted provider, they are responsible to pay for any portion of service costs left unpaid by the insurance. Contact the insurance to obtain authorization from the plan to provide services to members of the plan. In cases where authorization is denied because mental health benefits under the plan have been exhausted, obtain written documentation that the client has exhausted their mental health benefits.

Note: Ensuring that clients receive appropriate care is our priority. Staff completing financial screening should not make the determination to turn away a client due to their health coverage; this decision is between the client and their therapist. Financial operations staff are responsible for informing clients of their existing OHC and their responsibilities.

To obtain authorization from the private insurance, reach out to the insurance to determine whether they cover mental health or behavioral health services. In addition to requesting authorization to provide services, obtain billing information and instructions such as the effective date of coverage, what services are billable, provider disciplines eligible to bill for services, verify the policy number, and confirm where/how to submit claims for mental health services.

Those authorized to receive services from the provider or those who have exhausted their mental health insurance benefits are only responsible for unpaid costs up to the UMDAP annual liability. Those not authorized to receive services from an out of network provider are responsible for the full cost of the service that was left unpaid by the insurance. If the client has Medi-Cal in addition to the insurance, as long as the insurance was billed, Medi-Cal will become responsible for the portion of service costs left unpaid by the insurance plan.

Pursue new or renewed authorization when the existing authorization runs out or expires or if the client changes insurance plans. For those who exhausted their mental health benefits during the plan year, pursue authorization from the insurance when additional benefits become available (usually the following January).

Clients covered by private insurance including Medicare Advantage Plans must authorize the provider to release service information for billing and the insurance to pay the provider directly. This authorization is done using the Insurance Authorization and Assignment of Benefits form or similar form approved by agency administration. This form must be signed and dated prior to billing the insurance company. Only one form is needed for the entire legal entity. The Insurance Authorization and Assignment of Benefits form must be signed as soon as the insurance coverage is identified. Place the signed form in the client's financial record and provide a copy to the client.

Verifying Other Health Coverage (OHC) Benefits

Medi-Cal is the payer of last resort. Federal and State law requires all Medi-Cal beneficiaries to report any additional coverage they have from private insurance or OHC. When Medi-Cal learns that a beneficiary has OHC, their eligibility record is updated to include the insurance information. Insurance information is returned in the Medi-Cal eligibility check as OHC or Other Health Information. Below are sample eligibility messages that include insurance or OHC.

SUBSCRIBER LAST NAME: XXXX. EVC #: XXXX. CNTY CODE: 19. PRMY AID CODE: 60. 1ST SPECIAL AID CODE: 4F. MEDI-CAL ELIGIBLE W/NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (123) 123-1234. HCP: KAISER CALL: (123) 123-1234. PCP: DR. K CALL: (123) 123-1234. OTHER HEALTH INSURANCE COV UNDER CODE K - KAISER. CARRIER NAME: KAISER PERMANENTE HEALTH PLAN. ID: XXXXXXXXX. COV: OIM P

SUBSCRIBER LAST NAME: XXXX. EVC #: XXXX. CNTY CODE: 19. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (123) 123-1234. HCP: CARE FIRST CALL: (123) 123-1234. PCP: DR. C CALL: (123) 123-1234. OTHER HEALTH INSURANCE COV UNDER CODE V. CARRIER NAME: CALIFORNIA CARE BLUE CROSS HMO. ID: XXXAXXXXX. CARRIER NAME: DENTAL NET BLUE CROSS. ID: XXXAXXXXX. COV: OIM P D

If OHC information is not updated timely, the Medi-Cal eligibility check might return outdated or erroneous OHC information. If a client states that they are no longer covered by OHC or never had insurance coverage, the information can be removed from the client's eligibility record. Obtain verification such as a letter of coverage termination or documentation from the insurance company stating that the client was never a member and request that the OHC information be removed from the client's eligibility record. Submit the request to DHCS's Third Party Liability and Recovery Division (TPLRD). TPLRD has a secure online form to remove erroneous OHC indicators. The online OHC Removal Form is available on the OHC Processing Center website at http://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx. Allow 72 hours for the form to process. The form may have to be submitted more than once. Staff may also assist clients in reaching out to their eligibility or case worker to have the OHC(s) removed from their Medi-Cal eligibility record.

Medicare

Medicare is the federal health insurance program for the aged and disabled. Those who are aged 65 and older as well as those under 65 who are disabled, are in kidney failure (End-Stage Renal Disease [ESRD]), or who have ALS (Amyotrophic lateral sclerosis, also known as Lou Gehrig's Disease) are eligible for Medicare. Medicare covers inpatient hospital care, skilled nursing, hospice care under Part A, doctor office visits, outpatient services, some preventative care, and some medical equipment under Part B, and Prescription drugs under Part D. DMH outpatient professional services are covered under Medicare Part B.

Original Medicare vs Medicare Advantage Plans

While the Medicare program helps with the cost of health care, it does not cover all medical expenses or the cost of most long-term care. Medicare beneficiaries have the option to enhance original Medicare with a supplemental Medigap insurance policy from a private insurance company or to join a Medicare-approved plan from a private company that bundles Part A, Part B, and Part D for health and drug coverage as an alternative to Original Medicare.

Original Medicare

Medicare beneficiaries who have not enrolled in a Medicare Advantage Plan are enrolled in Original Medicare. Original Medicare beneficiaries who have Medicare Part B can receive outpatient services without prior authorization. Medicare does not require prior authorization to provide outpatient services. All DMH providers can see clients with Original Medicare Part B. Consult with agency administration regarding Medicare requirements related to obtaining signatures from the client granting permission to release service information for billing and authorizing direct payment from Medicare to the provider/Legal Entity. Place a signed copy of the form in the client's financial record .

Financial operations staff should call Noridian Provider Contact Center at 1-855-609-9960 or use Noridian's online portal (https://www.noridianmedicareportal.com/) to verify the coverage effective date and the Medicare Beneficiary Identifier (MBI) number. Medicare eligibility may also be verified using a clearinghouse or sending Noridian a HIPAA 270/271 transaction.

Medicare Advantage Plan

Medicare Advantage Plans, sometimes called Part C and previously known as Medicare Risk HMOs, are Medicare-approved plans offered by private insurance companies designed to provide covered benefits beyond what Original Medicare offers to beneficiaries. Clients can usually only be seen by providers within the plan network for services to be covered by their Medicare Advantage Plan. To be eligible to enroll in a Medicare Advantage plan clients must have Medicare Parts A and B.

Medicare Advantage is private insurance, or OHC. Contact the Medicare Advantage plan to obtain authorization prior to delivering services to a client enrolled in that plan when it is clinically appropriate to do so. In cases where authorization is denied because mental health benefits under the Medicare Advantage plan have been exhausted, obtain written documentation that the client has exhausted their mental health benefits. If the Medicare Advantage plan does not authorize DMH services and the client, in consultation with their clinical team, decides to continue with receiving DMH services, then the client is responsible for the full cost of services left unpaid by their Medicare Advantage plan. If the client is covered by Medi-Cal in addition to coverage from the Medicare Advantage plan, then Medi-Cal will take on the responsibility for the cost of services left unpaid by the plan as long as the Medicare Advantage Plan was billed first.

Pursue new or renewed authorization when the existing authorization runs out or expires or if the client changes Medicare Advantage plans. For those who exhausted their mental health benefits during the plan year, pursue authorization from the insurance when additional benefits become available (usually the following January).

To obtain authorization, reach out to the Medicare Advantage Plan to determine whether any coverage of mental health services remains. In addition to requesting authorization to provide services, obtain billing information and instructions such as the effective date of coverage, what services are billable, provider disciplines eligible to bill for services, verify the policy number, and confirm where/how to submit claims for mental health services.

Clients covered by Medicare Advantage Plans must authorize the provider to release service information for billing and the insurance to pay the provider directly. Medicare Advantage is private insurance. Authorizations for billing private insurance, including Medicare Advantage Plans, are done using the Insurance Authorization and Assignment of Benefits or similar form approved by agency administration. This form must be signed and dated prior to billing the Medicare Advantage Plan. Only one form is needed for the entire legal entity. This form must be signed as soon as the insurance coverage is identified. Place the signed form in the client's financial record and provide a copy to the client.

UMDAP & Third Party Payments

Regardless of the total cost of care a client receives, the client is only responsible for any balance equal to or less than the annual liability after payment by the third-party payer. Any balance remaining after third-party payments and the UMDAP annual liability are applied will be covered by funding plan. Under no circumstances should a client be billed the entire annual liability amount if the client has not received that amount in actual services.

Below are examples of how third-party payment, annual liability, and funding plans are applied.

Multiple Services During the Same Annual Charge Period

A client with third-party insurance and a $100 annual liability received two services on two different days within the same annual charge period. The cost of care for Service #1 is $1,000 and the client is responsible to pay up to $100 of their annual liability. If the insurance pays less than the total cost for the service, the client would be responsible for the remaining balance up to their annual liability. In this example, the third-party payer pays $925 for the first service. Since the balance is less than the client's annual liability, the client would only owe $75 to cover the cost of care left unpaid by the insurance.

Service #1	
Cost of Care	$1,000
Payment by Third-Party Insurance	-$925
Cost of Care Balance	$75
Annual Liability Payment by the Client	-$75
Client's Annual Liability Balance for this Annual Charge Period	$25

The cost of care for Service #2 is $1,200. Since the client paid $75 for Service #1, their annual liability balance is $25. If the insurance pays less than the total cost for the service, the client would be responsible for the remaining balance up to their annual liability. In this example, the third-party payer pays $1,100 for the second service. Even though the cost left unpaid by the insurance is $100, the client is only responsible for $25 of the remaining balance. After the client pays the $25, the remaining balance of $75 will be covered by the funding plan. The client's annual liability for the rest of the annual charge period will be $0.

Service #2	
Cost of Care	$1,200
Payment by Third-Party Payment Insurance	-$1,100
Cost of Care Balance	$100
Annual Liability Payment by the Client	-$25
Funding Plan	-$75
Client's Annual Liability Balance for this Annual Charge Period	$0

Clients Receiving Services at Multiple Legal Entities

Legal Entity A completed the initial financial screening interview on May 9, 2022 and determined the client's annual liability to be $350. The client's annual charge period was from May 9, 2022 through May 8, 2023. The client has no other third-party coverage.

Legal Entity A provided services on two different days in the same annual charge period: May 9, 2022 and May 24, 2022.

- Cost of May 9th service was $100
- Cost of May 24th service was $50

No other services were provided to the client during the month of May 2022. Legal Entity A must collect payment from the client of $150 for services delivered during May 2022.

Original Annual Liability	$350
Total Cost of Care for May 2022 (Service dates: May 9 and May 24)	$150
Client responsibility	-$150
Cost of Care Balance	$0
Client's Annual Liability Balance for this Annual Charge Period	$200

The client did not receive services during the month of June or July 2022.

On August 12, 2022, the client requested services from Legal Entity B. Legal Entity B must accept the UMDAP annual liability and annual charge period set by Legal Entity A and must communicate with Legal Entity A costs incurred against the client's annual liability. The client received mental health services from Legal Entity B totaling $75. Legal Entity B must bill the client $75 for services delivered for the month of August 2022 because it is less than the annual liability balance for the charge period.

Client's Annual Liability Balance for this Annual Charge Period	$200
Cost of Service for August 2022	$75
Client responsibility	-$75
Cost of Care Balance	$0
Client's Balance for This Annual Liability Period	$125

The client has a remaining annual liability balance of $125 for this annual charge period. This means that the client may be seen at either Legal Entity A or B or any other specialty mental health provider and will only be responsible for up to the remaining annual liability balance of $125, if the client incurred $125 or more in actual charges for services received.

Who to Bill When Clients Have OHC

DMH Policy No. 801.06 – Private Prepaid Healthcare Treatment and Billing states governs when DMH providers may see clients with OHC and when those clients are eligible to be placed on an UMDAP annual liability. Who to bill and when to bill depends on the client's coverage and whether services were authorized by the insurance. The following table reflects the client's responsibility to pay for services rendered based on health coverage types:

- OHC & Medi-Cal w/no SOC
- OHC & Medi-Cal w/SOC
- OHC only (no Medi-Cal)

Clients who have OHC in addition to full scope Medi-Cal with no share of cost must not be charged, even when the OHC does not pay. Medi-Cal is responsible for the cost of care left unpaid by the OHC.

Coverage Type	OHC Authorized Services?	Bill OHC?	Bill Unpaid Balance to Medi-Cal?	Bill Client?	Comment
OHC & Medi-Cal with no Share of Cost	Yes	Yes	Yes	No	Bill Medi-Cal after receiving an approval or denial from the OHC or after 90 days if the OHC did not respond. Medi-Cal is responsible for the balance not paid by OHC.
	No	Yes	Yes	No	
OHC & Medi-Cal with Share of Cost	Yes	Yes	Yes, once MEDI-CAL eligible	**No**, if the client is Medi-Cal eligible **Yes**, if the client has an outstanding SOC balance	Bill Medi-Cal the balance after Share of Cost is cleared **AND** the OHC approved/denied the claim (or after 90 days with no response from the OHC). Bill the client the annual liability, the cost of service, or Share of Cost, *whichever is less*.
	No	Yes	Yes, once MEDI-CAL eligible		
OHC Only (No Medi-Cal)	Yes	Yes	N/A	Yes	Bill the client the annual liability or the cost of service, *whichever is less*.
	No	No	N/A	Yes	Bill client the Full Cost of Care.

TRICARE, CHAMPVA, and Victims of Crime

TRICARE/CHAMPVA

To fulfill the medical coverage needs of servicemembers, veterans, and their families, there are several plans available through Military Health Systems and the Department of Veterans Affairs (VA). The two main programs available are TRICARE and CHAMPVA.

TRICARE

TRICARE is the health care program for the military. It provides comprehensive health care coverage and is provided to active-duty service members, most retired military personnel, and their dependents. The program's previous name, the Civilian Health and Medical Program of Uniformed Service (CHAMPUS), is often confused with CHAMPVA, the healthcare coverage program offered through the VA.

TRICARE coverage is treated as OHC. It is primary to other OHCs. TRICARE does not require pre-authorization for most mental health services, however, calling for authorization ensures that the services offered to the client are covered treatment and that the agency and the practitioner are eligible to provide services and bill. An approved authorization also makes the client eligible for an UMDAP annual liability. TRICARE has contracted with Health Net as the Managed Care Support Contractor (MCSC) for its providers in the West Region. Contact Health Net at 1 (844) 866-9378 to obtain authorization to provide services when it is clinically appropriate to do so. Pursue new or renewed authorization when the existing authorization runs out or expires.

TRICARE in Addition to Other Payers

TRICARE is available to active-duty and retired military as well as to their spouses and dependent families. Clients who have TRICARE also might have additional insurance such as Medicare or private insurance. Below is a guide to who pays first when the client has coverage in addition to TRICARE. In the first four scenarios that follow, if the client also has Medi-Cal, Medi-Cal is the last third-party payer.

TRICARE, MEDICARE, AND OHC

Payers	1st Payer	2nd Payer	3rd Payer
• Medicare; • TRICARE; and • Other health insurance ○ Health insurance you have in addition to TRICARE, such as Medicare or an employer-sponsored health insurance.	Medicare	OHC	TRICARE
• Medicare; • TRICARE; and • OHC through current employer with more than 20 employees	OHC through current employer	Medicare	TRICARE
• Medicare; • TRICARE; and • OHC through current employer with fewer than 20 employees	Medicare	OHC through current employer	TRICARE
• Medicare; • TRICARE; and • Indian Health Service	Medicare	TRICARE	Indian Health Service
• Medicare; • TRICARE; and • Medi-Cal	Medicare	TRICARE	Medi-Cal

CHAMPVA

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive healthcare insurance program in which the VA shares the cost of covered healthcare services and supplies with eligible beneficiaries. CHAMPVA beneficiaries are the spouses, widow(ers)s, and children of qualifying Veterans. The CHAMPVA program covers most healthcare costs that are deemed medically necessary, upon confirmation of eligibility.

To be eligible for CHAMPVA the individual cannot be eligible for TRICARE and must be:

- The spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office
- The surviving spouse or child of a veteran who died from a VA-rated, service-connected disability
- The surviving spouse or child of a veteran who was at the time of death rated permanently and totally disabled from a service-connected disability
- The surviving spouse or child of a military member who died in the line of duty, not due to misconduct

To be eligible for CHAMPVA benefits, you must enroll in, and remain enrolled in Medicare Parts A and B. Beneficiaries must enroll in Medicare 90 days prior to their 65th birthday. Declining Part B coverage makes the individual ineligible for CHAMPVA benefits. After enrolling in Medicare, they will receive a Medicare card indicating that they have both Medicare Part A and Medicare Part B coverage and must notify CHAMPVA of the new coverage.

CHAMPVA coverage is treated as OHC. CHAMPVA coverage is secondary to Medicare and Medigap. CHAMPVA requires pre-authorization for mental health services in some situations, particularly when the client is receiving outpatient services in excess of 23 per calendar year and/or more than two (2) sessions per week, home visits, inpatient services, and residential care. Calling for authorization ensures that the services offered to the client are covered treatment. An approved authorization also makes the client eligible for an UMDAP annual liability. Contact the Veterans Affairs (VA) Medical Center to obtain authorization to provide services when it is clinically appropriate to do so. Pursue new or renewed authorization when the existing authorization runs out or expires.

Victims of Crime

The California Victim Compensation Board (CalVCB) works to reduce the impact of crime on victims' lives by providing financial assistance for crime-related expenses and assisting victims to connect to services and support to help restore their lives. Obtain a copy of the victims of crime (VOC) verification letter to add to the client's Financial record.

CalVCB requires providers to submit documentation and receive clearance before the provider can be added to their database. To obtain clearance, the providers must email info@victims.ca.gov the signed and dated W9 (billing name/address should match what is listed on the CMS 1500 form) and a copy of the provider's license issued by the Board of Behavioral Sciences, Board of Psychology or Medical Board.

Billing for Mental Health Services

Contract providers must submit documentation and get authorization before the provider receives payments from CalVCB. Providers must bill the client's private and/or public healthcare insurance before filing a claim with CalVCB. If the expense is not covered or is partially covered by the other insurances, a copy of the explanation of benefits (EOB) needs to be provided. Providers have 90 days from the date of service to submit the claim. Mental health-related bills should be submitted on the CMS 1500 form for mental health and outpatient medical charges.

All bills should include:

- The patient's or client's name
- The payee's name, address and tax ID
- Date of service
- CPT codes
- The payee's or treating therapist's license number

The VOC payer is secondary to Medi-Cal. Medi-Cal must approve or deny the claim prior to the claim being submitted to the VOC payer. This ensures that the client is not charged for any cost of services left unpaid by prior payers. The annual liability for clients covered by VOC is $0.

Financial Forms

Financial Forms

One of the objectives of the financial screening interview is to obtain information about the insurance and benefits the client is able to access in order to pay for services received. Another objective is to determine whether the client has the resources to pay for all or part of services personally. The PFI is the form used to document this information. Other financial forms acknowledge the financial agreement between the client and the provider or allow the provider to submit claims to third-party payers for the services the client received.

Previous chapters discussed the PFI in detail. This chapter will focus on the following financial forms:

- Financial Obligation Agreement
- Insurance Authorization and Assignment of Benefits

Place all signed forms in the client's financial record. Copies of signed forms must be given to the client.

The PFI and all forms discussed in this chapter are included in the Forms Appendix of this Manual.

Financial Obligation Agreement

The Financial Obligation Agreement (FOA) is a written agreement between the client and the provider. This agreement details the annual charge period, the annual liability amount or the maximum amount to be paid for all services received during the annual charge period, the payment plan, and the client's responsibility to report any change in their financial circumstances and/or in their health insurance coverage. The Financial Obligation Agreement is required for all clients regardless of whether they have an annual liability. Complete this agreement during the initial financial screening interview, and annually thereafter, for every client receiving mental health services. The Financial Obligation Agreement requires signatures from both the client and the staff conducting the financial screening interview. Clients should sign and date the agreement whether they have an annual liability or zero annual liability. The date on each signature line must be the date that person signed the form. Place the signed form in the client's financial record and give a copy of it to the client.

Payment plans should allow the client/payor to pay off their debt in the shortest time possible. The payment plan should rarely exceed the anticipated length of treatment, and never exceed one year.

Insurance Authorization and Assignment of Benefits

Prior to billing private insurance for services rendered, the client should authorize the provider to release information. Additionally, the client should agree to allow the insurance to pay the provider group directly (that is, assign their benefits) for the services rendered. Clients with private insurance, including those enrolled in Medicare Advantage Plans, sign the Insurance Authorization and Assignment of Benefits (IAAB) or other similar form. *Do not use this form for clients who are enrolled in Original Medicare and have not assigned their Medicare over to a Medicare Advantage Plan.* The IAAB form used by directly operated programs mirrors the paper CMS 1500 form and requires the client to sign twice, as it is required on the CMS 1500. The top section of the IAAB form authorizes the provider to release service information required for claiming; the bottom assigns benefits and authorizes the insurer to pay the billing provider directly. Having both signatures on the form allows providers to enter "Signature on File" where client signature is requested on paper insurance claim forms and in the appropriate segment of the electronic claim. The form is to be dated with the current date. Contract providers may use the IAAB form or a similar form that has been approved by agency administration and/or counsel.

Obtain the client's signature during the initial financial screening interview, at reevaluation, or when the client reports enrolling in a private insurance plan or in a Medicare Advantage Plan in the middle of the annual charge period. Place the signed form in the client's financial record and give a copy of it to the client.

If the client refuses to sign the IAAB, then they must sign both signature fields on the paper CMS 1500 claim form in order for providers to submit claims for that client. If the client will not sign the paper claim, then the service cannot be billed to the insurance. Clients with private insurance or who are enrolled in a Medicare Advantage Plan who refuse to sign both the IAAB and the CMS 1500 form are not cooperating with the financial screening process and are potentially liable for the full cost of care.

NOTE: ALTHOUGH AUTHORIZATION FROM MEDICARE IS NOT REQUIRED PRIOR TO RENDERING OUTPATIENT SERVICES TO MEDICARE BENECIARIES, LEGAL ENTITY CONTRACT PROVIDERS MUST CONSULT WITH THE AGENCY'S ADMINISTRATION REGARDING MEDICARE'S REQUIREMENTS RELATED TO COLLECTING CLIENT SIGNATURES. ADHERE TO AGENCY GUIDANCE ON OBTAINING THE CLIENT'S PERMISSION TO BILL MEDICARE.

Obtaining Signatures on Forms

Signatures are required on all forms. The client or responsible person's signature on forms indicates that the information provided is true and correct to the best of their knowledge, that they authorize the provider to submit claims for services, and that they understand their responsibilities regarding payments for services. When staff sign forms, it identifies who completed the financial screening and indicates that an explanation of the client's liability and responsibilities was provided. The date accompanying the signature must be the date the person signed the form.

Signatures can be written out by hand, electronic, or digital. Verbal consent is not allowed on any financial form. If a client is unavailable to sign the required forms in person at the time of financial screening, the financial forms that have been prepared can be sent to the client by mail, fax, email, or through a patient portal, if available, for signature. Signed forms can be returned in person, by mail, fax, email, or patient portal. Clients receiving video telehealth services can have their signed forms screen-captured by the practitioner rendering the services.

If the client refuses to sign financial forms, financial operations staff should engage the clinical team to help convince the client to sign. Refusing to sign forms authorizing the provider to bill insurance could result in the client being responsible to pay the full cost of care.

Financial Document Retention

Keep documents used in financial screening and/or benefits establishment for 10 years after discharge or from the date of completion of any audit, whichever is later. For minors, keep documents used in financial screening and/or benefits establishment until one (1) year after the minor reaches the age 18, but not less than 10 years from the date of completion of any audit, whichever is later.

Directly operated programs must return originals of vital records to clients and then shred hard copies of documents related to financial screening and/or benefits establishment after they have been scanned into the client's financial record.

Client's Right to Refuse to Provide Financial Information

The client has the right to refuse to cooperate with providing financial screening information or the incompletion of the financial screening process. Some examples of client refusal are listed below:

- Failure to provide billing information of the third-party payers
- Failure to sign and date applicable authorization forms to complete the financial screening process and allow billing of third-party payers
- Failure to provide supporting verification

Financial operations staff are encouraged to get the clinical team involved if a client refuses to cooperate with the financial screening process or refuses to provide supporting verifications. With the help of the clinical team, they can help gather needed financial screening information to complete the financial screening process. It is imperative for the clinical team to let the client know that when they provide the financial screening information, they may potentially be responsible for less than the actual cost of service.

Verification

Verification of the information reported during the financial screening interview is required. This includes verifying the client's identity as well as financial information. Copies of what was used as verification should be placed in the client's financial record. Clients unable to provide verification may continue to receive services.

Identity

As part of the financial screening process, providers must make a "good faith effort" to verify the client's identity by requesting proof of identity. The objective of verifying identity in the financial screening interview is to help confirm that the benefits coverage reported belong to the person providing the information or that the client has the right to access that coverage. Verify identity using a government issued form of identification (ID) such as a California Driver License, a California ID, or a US Passport. Other forms of ID are also acceptable. Identification should contain a photo of the client as well as the client's name and signature such as a school ID or an employee ID. Request a secondary picture ID when presented with government issued IDs without photos such as a Social Security card, a Benefit Identification Card (BIC) from Medi-Cal, or a birth certificate. Insurance cards, such as the Medi-Cal BIC and Medicare card alone are NOT sufficient to establish identity.

DO NOT TURN AWAY CLIENTS BECAUSE THEY DO NOT PRESENT AN ID. NOT HAVING AN ID MUST NOT BE A BARRIER TO RECEIVING SERVICES.

Financial Information

Verification of Social Security Number (SSN), employment, current address, liquid assets, allowable expenses, and income is required. Place copies of the documentation used to verify the information on the PFI in the client's financial record. Clients could become responsible for the full cost of care if they refuse to provide verification of income, assets, expenses, and coverage from third-party payers. Request supporting documentation when it is clinically appropriate to do so. Do not place clients on full cost of care if it was not clinically appropriate to ask for supporting documentation.

Below is a table with examples of the forms of documentation that are appropriate to use to verify the information entered on the PFI. Provide the client with a checklist of what is needed for best results. Ask the client to make the supporting documentation available at their financial screening interview or at the next visit when it is clinically appropriate.

PFI Field(s)	Examples of Acceptable Supporting Documentation
Client identity	• Government issued photo ID or other photo ID with signature • School ID • Employee ID • ID without photo ○ *Requires secondary ID*
Social Security Number (SSN)	• Social Security Card • W-2 • Paystub showing full SSN (*Do not place clients on full cost of care if they are unable to present verification of SSN*)
Health Insurance Card	• Benefits Identification Card (BIC) • Medicare Card • Private/Commercial Insurance Card
Employment	• Paystub – at least the last three stubs • Tax Return

Unearned Income
– *Includes governmental benefits and court ordered child support/alimony*
	• Benefits Award letter(s) from:
	  ○ Employment Development Department (EDD) (Unemployment)
	  ○ VA
	  ○ SSA
	• Court order for support payments received

In-Kind Support	Completed and signed In-Kind Form

PFI Field(s)	Examples of Acceptable Supporting Documentation
Liquid Assets	• Checking statements • Savings statements • IRA statements • Market Value of Stocks • Bonds • CD • Mutual Fund Certificate
Allowable Expenses ***– Court ordered child support/alimony***	• Court order • Receipt • Cancelled check
Allowable Expenses ***– Childcare payments***	• Receipt • Cancelled check
Allowable Expenses ***– Dependent Support Payments*** ○ ***Members of the UMDAP household only (i.e., Children/Spouse/ Parents, etc.)***	• Receipt(s) • Cancelled check
Medical Expenses ○ **Monthly health/dental insurance premiums** ○ **Installment payments on hospital/dental bills**	• Invoice • Receipt • Cancelled check
Monthly Mandated Deductions from Gross Income	• Paystubs

If verification is not presented at the financial screening interview, complete the PFI based on the information provided by the client during financial screening. Giving the client a reasonable due date, or deadline, for presenting some form of verification is helpful and sets an expectation for the client. Inform the client that intentionally avoiding or refusing to provide supporting documentation could make them responsible for the full cost of care.

In-Kind

In-Kind income is a form of financial support that is not from earned or unearned income. Clients may receive financial or other support such as housing, utilities, food, clothing, or cash from a person in exchange for a service or without incurring a financial liability. To confirm that the client is receiving in-kind support, the provider of the support must complete the Verification of In-Kind Source of Income form. Clients receiving this type of support must submit this form whenever they are being reevaluated for as long as they are receiving this kind of support.

Steps to take to obtain verification of In-Kind income:

- The Verification of In-Kind Source of Income form contains confidential information. Complete the Release of Information Form (MH 602) to allow the provider of in-kind support to verify information.
- Issue the Verification of In-Kind Source of Income form to the in-kind provider to complete.
- Follow up with the client or In-Kind provider if the form is not returned within the agreed upon number of days. Ten (10) business days is recommended.
- Place the completed In-Kind form in the client's financial record.

Reevaluations

All clients are to be reevaluated, or rescreened, annually. Clients must also be reevaluated whenever they report a change in financial circumstances or insurance coverage at any point within the annual charge period.

Annual Reevaluation

The objective of the annual reevaluation is to determine how services will be paid for in the upcoming annual charge period. Reevaluations are completed on or near the anniversary date of the UMDAP annual liability period (also called the UMDAP date) to determine whether the client's financial situation or insurance coverage has changed. Annual reevaluations ensure that the client's financial profile has accurate payer information to prevent the client from being overcharged or inappropriately charged for mental health services.

Clients should be reevaluated no more than 30 days before the UMDAP date, and no later than the client's first visit after the end of the annual liability period. The UMDAP annual liability period is continuous and the UMDAP anniversary date will remain the same, regardless of when the PFI is completed. The new annual charge period is to keep the original UMDAP month and day; only the year will be updated. For example, if a client's initial UMDAP date was January 22, 2022, the annual charge period would be January 22, 2022 through January 21, 2023. The new annual charge period at reevaluation will be January 22, 2023 through January 21, 2024.

To facilitate reevaluating the client on time, clients should be notified in advance that a financial reevaluation is due. Sending the Reevaluation Follow-Up Letter, included in the Forms Appendix, or something similar is highly recommended. Place a copy of the Reevaluation Follow-Up Letter into the client's financial record.

The annual reevaluation is similar to the initial financial screening interview. Gather current financial and healthcare coverage information from the client to determine their ability to pay. A new PFI and Financial Obligation Agreement must be completed during the annual reevaluation along with any other applicable financial forms. The client must provide current supporting verification of income, assets, and allowable expenses. Additionally, it is important to confirm the client's current mailing address and phone number to support effective communication and claiming.

Telephone Reevaluation

Telephone reevaluations are acceptable, however, the client must sign the PFI, the Financial Obligation Agreement, and any other applicable forms at the next visit or as soon as possible after the telephone reevaluation. Clients must also provide any missing information, verification of income, assets, and allowable expenses. Confirm the client's current address and phone

number during the telephone interview. Clients who fail to complete the reevaluation or to provide verification in person at their next appointment, by mail, or by other means, could be responsible for the actual cost of care until the reevaluation is complete and verification is received.

Reevaluating Full Scope Medi-Cal Clients

Financial operations staff may use the eligibility response from Medi-Cal to update the PFI when the clients have full-scope Medi-Cal. Enter *"Eligibility verified through Medi-Cal eligibility response"* on Line 28 of the PFI. This PFI may be placed in the client's financial record but a signature must be pursued. Obtain the client's signature on the PFI as soon as possible. Place the completed PFI in the client's financial record.

Staff must verify coverage and eligibility with other payers when clients have coverage in addition to Medi-Cal. Contact the other payers to confirm that the information provided by Medi-Cal is correct. Verification of the other coverage must be obtained from the client.

Note: Clients whose annual charge period has expired or who have not been reevaluated could be made responsible for the actual cost of care until the reevaluation is completed. Clients may be considered full cost of care until the reevaluation can be completed.

Changes in Coverage or Financial Situation

When a client reports a change in financial circumstances or healthcare coverage, the client must be reevaluated to document the change in coverage and/or to determine if there is a change in their annual liability. The annual liability amount may be adjusted up or down at any point during the annual charge period if warranted by a reported change in the client's financial situation and/or health coverage. Providers must obtain documentation supporting the reported changes before adjusting the annual liability for the remainder of the charge period.

Clients will be reevaluated to determine if an adjustment to their financial obligation is necessary for the remainder of their annual liability period. The existing PFI and Financial Obligation Agreement should be updated and initialed by the client or new forms completed and signed. Additional forms for Medicare or private insurance may be needed as well. Obtain signatures on new and newly completed forms as well as supporting documentation of the reported changes. Place the completed forms in the client's financial record and give a copy to the client.

Clients are responsible for prompt notification of a change in financial situation. Adjustments to the annual liability cannot be retroactive and are effective as of the date of notification.

NOTE: Once a client has incurred costs of services that are equal to or exceed the annual liability amount, the client is responsible to pay the cost of services or the annual liability amount, whichever is lower. The only exception is when the client is granted Medi-Cal retroactively. In these cases, the annual liability can be adjusted dating back to the first date of Medi-Cal eligibility.

Maintaining the Financial Record

Financial Record

All providers must keep a record of all documents and actions taken related to the client's financial account. This includes all financial information collected during the financial screening interview, insurance coverage, documentation supporting that information and coverage, eligibility responses, and a recounting of contact or communication with the client and the third-party payers responsible for the client's services. Below is a list of forms, documents, and verification that should be included in a client's financial record. The list is not exhaustive. Any document or communication that impacts the client's responsibility to pay for services and/or that allows or disallows the provider to submit claims for the services rendered must be included in the financial record for the client.

- Payer Financial Information (PFI) form
- Financial Obligation Agreement
- Insurance Authorization and Assignment of Benefits (IAAB) or similar form
- Photocopy of current photo identification
    - Government Issued Identification card, Driver's License, or Passport
- Copies or documentation (notes) of any communication or correspondence to or from the client, any third-party payers, or other persons providing financial information
- Eligibility verification
- Authorizations from insurance
- Explanation of Benefits (EOB) or Remittance Advices (RA)
- Reevaluation Follow-Up Letter
- Request for Annual Liability Balance
- Therapeutic Fee Adjustments (TFA)
- Authorization for Request or Use/Disclosure of Protected Health Insurance Information (PHI)
- Verification of healthcare coverage, employment, income, allowable expenses, and liquid assets
    - Health insurance cards such as the Medi-Cal Benefits Identification Card (BIC), Medicare card, and private/commercial insurance card
    - Paycheck stubs
    - Verification of In-Kind Income
    - Bank statements
    - Court orders related to support received or paid

Medi-Cal Eligibility Guidelines

Medi-Cal Eligibility Guidelines

Medi-Cal is health care coverage for qualifying persons who live in California, and who have income and resources below the State's established limits.

Who Can Potentially Qualify for Medi-Cal?

Refer clients in the following categories to their local DPSS office to apply for Medi-Cal.

- Young Adults aged 19-25 who meet income criteria regardless of immigration status
- Adults aged 50 or older who meet income criteria regardless of immigration status
- People who are aged (65 years old or older), blind, or disabled
- Pregnant individuals
- People in a skilled nursing facility or intermediate home care
- People with a lawful permanent resident status who meet income or resource criteria
- A parent or caretaker relative of a child under 21 if:
    - The child's parent is deceased or doesn't live with the child
    - The child's parent is incapacitated
    - The child's parent is under employed or unemployed
- Women who have been screened for breast cancer and/or cervical cancer
- Former Foster Youth up to the age of 26 who were in Foster Care on their 18th birthday
- People receiving Cash Aid, such as CalWORKs, General Relief, Refugee Assistance, or SSI/SSP

Citizenship and Immigration Status to Qualify for Medi-Cal

Individuals who are natural-born or naturalized citizens, who were under lawful admission for Permanent Residence in the U.S., and undocumented immigrants may be eligible for Medi-Cal. Some undocumented clients may be eligible for pregnancy-related and emergency services; others are eligible for full-scope Medi-Cal benefits depending on their immigration status, age, and those that have limited income and resources.

Applying for Medi-Cal Through DPSS

- In person at any DPSS district office: Office Locations DPSS
- Call the DPSS Customer Service Center at: (866) 613-3777
- BenefitsCal website: BenefitsCal (https://benefitscal.com/)
- Covered California website: Covered California™ (https://www.coveredca.com/)

Training Inquiries

CBO offers financial screening training for financial operations staff, front desk staff, their supervisors, managers, and administrators. Training is strongly recommended for staff prior to completing financial operations tasks. For information about the financial training schedule, please contact CBO:

- E-mail CBO Training at RMDTraining@dmh.lacounty.gov
- Call CBO Hotline at (213) 480-3444
- Open a HEAT ticket using HEAT Self-Service: https://lacdmhheat.saasit.com

Forms Appendix

Forms Appendix

The Department of Mental Health (DMH) collects information during financial screening to obtain needed information to determine the client's ability to access third-party benefits or to personally contribute to paying for the cost of services. Below is a list of forms included in this Appendix.

- ✓ Payer Financial Information (PFI)
- ✓ Uniform Patient Fee Schedule
- ✓ Financial Obligation Agreement
- ✓ Insurance Authorization and Assignment of Benefits
- ✓ Verification of In-Kind Source of Income
- ✓ Reevaluation Follow-Up Letter
- ✓ Financial Profile Verification Request
- ✓ Automated Eligibility Verification System Response Log

The forms in this Appendix are used to obtain financial and healthcare coverage information from our clients.

Note: *Fillable forms can be found on the DMH internet website with CBO Bulletins. Click here to access the forms: CBO Financial Forms.*

Contractor Use of Forms in the Financial Forms Appendix

To facilitate the financial operations workflow, the PFI may be added to the agency's EHR as long as all fields are represented in the system. However, when it is printed from the EHR for audit purposes or when it is being given to the client, ***the PFI must appear in the format shown in this Manual***.

The Uniform Patient Fee Schedule used in UMDAP determination cannot be altered.

Contract providers may use the other forms and form letters included in this Appendix. Agencies choosing to customize the Financial Obligation Agreement or the IAAB or choosing to use a different type of agreement should consult with agency administration and/or agency counsel prior to implementation.

Payer Financial Information (PFI)

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 # | FAMILY REGISTRATION #

2 | MAIDEN NAME | DOB | MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP | SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME

3 | FOSTER CARE ☐YES ☐NO | VICTIMS OF CRIME ☐YES ☐NO | VETERAN ☐YES ☐NO | WORKER'S COMP ☐YES ☐NO | HOMELESS ☐YES ☐NO | CALWORKS ☐YES ☐NO | OTHER SPECIAL POPULATION:

4 | PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if other than the client or responsible person)

THIRD PARTY INFORMATION

5 | MEDI-CAL ☐YES ☐NO | ECM PLAN NAME | MEDI-CAL COUNTY CODE /AID CODE/ CIN # | HEALTHY FAMILIES ☐YES ☐NO | SHARE OF COST ☐YES ☐NO | SOC AMT $ | MEDI-CAL PENDING ☐YES ☐NO

6 | SSI PENDING ☐YES ☐NO | SSI APPLICATION DATE | REFERRED FOR BENEFITS ASSESSMENT ☐YES ☐NO DATE REFERRED | REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT

7 | MEDICARE ☐YES ☐NO | MEDICARE NUMBER (MBI) | LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐YES ☐NO DATE SIGNED | MEDI-GAP ☐YES ☐NO | TRICARE ☐YES ☐NO | CHAMPVA ☐YES ☐NO

8 | HMO/PPO ☐YES ☐NO | MEDICARE ADVANTAGE ☐YES ☐NO | NAME OF CARRIER | SUBSCRIBER POLICY ID # | SUBSCRIBER NAME

9 | CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS | INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS SIGNATURES OBTAINED ☐YES ☐NO

10 | ADD'L HMO/PPO ☐YES ☐NO | MEDICARE ADVANTAGE ☐YES ☐NO | NAME OF CARRIER | SUBSCRIBER POLICY ID # | SUBSCRIBER NAME

11 | CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS | INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS SIGNATURES OBTAINED ☐YES ☐NO

PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

12 | NAME OF PAYER | RELATION TO CLIENT | DOB | MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP | PAYER CDL/CAL ID/OTHER ID

13 | PAYER'S ADDRESS | CITY | STATE | ZIP CODE | TEL #

14 | SOURCE OF INCOME: ☐SALARY ☐SELF EMPLOYED ☐UNEMPLOYMENT INSURANCE ☐DISABILITY INSURANCE ☐SSI ☐GR ☐VA ☐Other Public Assistance ☐IN-KIND ☐UNKNOWN ☐OTHER: _____ | PAYER SS #

15 | EMPLOYER | POSITION | IF NOT EMPLOYED, DATE LAST WORKED

16 | EMPLOYER'S ADDRESS (Include City, State & Zip Code) | TEL #

17 | SPOUSE | ADDRESS (Include City, State & Zip Code) | SPOUSE'S SS #

18 | SPOUSE'S EMPLOYER | POSITION | IF NOT EMPLOYED, DATE LAST WORKED

19 | SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code) | TEL #

20 | NEAREST RELATIVE/RELATIONSHIP | ADDRESS (Include City, State & Zip Code) | TEL #

UMDAP LIABILITY DETERMINATION

21 LIQUID ASSETS		22 ALLOWABLE EXPENSES		23 ADJUSTED MONTHLY INCOME	
Savings	$	Court ordered obligations paid monthly	$	GROSS MONTHLY INCOME Self/Payer	$
Checking Accounts	$	Monthly childcare payments (necessary for employment)	$	Spouse	$
IRA, CD, Market value of stocks, bonds and mutual funds	$	Monthly dependent support payments	$	Other	$
TOTAL LIQUID ASSETS	$	Monthly medical expense payments	$	TOTAL HOUSEHOLD INCOME	$
Less Asset Allowance	$	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$	TOTAL FROM BOX 21	+ $
Net Asset Valuation	$			SUBTOTAL	+ $
Monthly Asset Valuation (Divide Net Asset by 12)	$	**Total Allowable Expenses**	$	LESS TOTAL FROM BOX 22	- $
				Adjusted Monthly Income	$
VERIFICATION OBTAINED ☐YES ☐NO		VERIFICATION OBTAINED ☐YES ☐NO		VERIFICATION OBTAINED ☐YES ☐NO	

24 | 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

OTHER

25 | PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐YES ☐NO WHERE: | FROM | TO | CURRENT ANNUAL LIABILITY BALANCE

26 | ANNUAL LIABILITY ADJUSTED BY | DATE | REASON ADJUSTED ☐TFA (enter date client signed below) ☐Other (describe below)
ANNUAL LIABILITY ADJUSTMENT APPROVED BY | DATE

27 | An explanation of the UMDAP liability was provided.
SIGNATURE OF INTERVIEWER | PROVIDER NAME AND NUMBER

28 | 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 24
SIGNATURE OF CLIENT
OR FINANCIALLY RESPONSIBLE PERSON | DATE

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

PFI (Rev 20230901) v1.12 - Fillable.pdf

Uniform Patient Fee Schedule

UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES
Effective October 1, 1989

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
	MEDI-CAL ELIGIBLE AREA**				
0- 569	37	33	30	27	24
570- 599	40	36	32	29	26
600- 649	45	40	36	32	29
650- 699	50	45	41	37	33
700- 749	56	50	45	41	37
750- 799	63	57	51	46	41
800- 849	71	64	58	52	47
850- 899	79	71	64	58	52
900- 949	89	80	72	65	59
950- 999	99	90	80	72	65
1000-1049	111	100	90	81	73
1050-1099	125	112	101	91	82
1100-1149	140	126	113	102	92
1150-1199	156	140	126	113	102
1200-1249	177	159	143	129	116
1250-1299	200	180	162	146	131
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456

Above $4200 Add $400 for each $100 additional income.

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (See back page).

Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

10/20/89

QUICK REFERENCE

MEDI-CAL ELIGIBILITY

All clients with monthly income at or below the Medi-Cal Family Budget Unit (MFBU) and have assets at or below the asset allowance area are presumed eligible if they meet aid eligibility requirements.

Maintenance need levels by Medi-Cal Family Budget Unit (MFBU) are:

MFBU			
1 - $602	3 - $934	6 - $1,417	9 - $1,825
2 - $750	4 - $1,100	7 - $1,550	10 - $1,959
2 - $934 (Adults)	5 - $1,259	8 - $1,692	

Asset allowances for 1989 are:

Persons		
1 - 2000	4 - 3300	7 - 3750
2 - 3000	5 - 3450	8 - 3900
3 - 3150	6 - 3600	9 - 4050

Aid categories commonly found in community mental health are:

REFUGEE - First 18 months in the U.S.	DISABLED - Meeting federal definition of disability.
AGED - 65 years of age and over.	AFDC - Aid to Family with Dependent Children.

MEDI-CAL SHARE-OF-COST

Persons with an extended treatment prognosis who are within a few hundred dollars of asset allowance and maintenance need levels may be eligible for Medi-Cal with a share-of-cost and/or real or personal property spend down.

For Example: A single 70-year old man would be eligible for Medi-Cal except that his income is too high. He has a $1,000 medical bill. He meets the low asset levels, but his income from retirement is $1,000 per month. His income is $1,000 minus the standard $20 disregard and the $24.90 payment for the Medicare Part B, leaving a "net" of $955.10. His "share-of-cost" for Medi-Cal is $955.10 minus $602 ("need level") or $353.10. Medi-Cal will pay the remainder of the $1,000 medical bill for that month and other months when he obligates the share of cost. He has to submit a Medi-Cal form MC-177 each month he obligates a share of cost above $353.10. His eligibility will be redetermined by Social Services each year.

All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or have incomes in the shaded area do not have an annual deductible.

1989 Uniform Patient Fee Schedule - Ref DMH Info Notice 98-13.pdf

Financial Obligation Agreement

ON AGENCY LETTERHEAD

Financial Obligation Agreement

Client Name: _____ DMH Client ID #: _____

California Welfare and Institutions Code 5709 states that a person receiving mental health services at a Los Angeles County operated or contracted facility may be responsible for the cost of those services in accordance with their ability to pay. As a result of your financial screening, a determination has been made regarding your financial responsibility, as indicated here.

☐ 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.

Change in Financial Situation: You are required to notify all service providers as soon as there is a change in your financial situation such as changes in employment status, income, cash assistance (e.g., Social Security Supplemental Income [SSI], Social Security Disability Income [SSDI], General Relief [GR], etc.) or when there is a change your Medi-Cal, Medicare, or other healthcare insurance coverage. In the event of changes in financial situation or insurance coverage, you must be re-evaluated to determine whether your financial obligation for the remainder of this annual liability period has changed. Failure to notify this provider of changes in your financial situation or insurance coverage could lead to you being responsible for the full cost of the services received.

- 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.

I understand that by signing this agreement, it is my responsibility to pay the monthly annual liability payment and report any change to my financial and/or health coverage immediately.

Agreement to Pay: We have agreed to allow you to make monthly payments to pay off this debt. You have agreed to pay $_____ per month for _____ months.

_____ _____

Client/Responsible Party Signature Date

_____ _____

Program Representative's Signature Date

Financial Obligation Agreement – English (Rev. March 2023) - NGA

Insurance Authorization and Assignment of Benefits

ON AGENCY LETTERHEAD

Insurance Authorization and Assignment of Benefits

I, _____ (_____),
Client Name *DMH Client ID#*

hereby authorize [AGENCY NAME] to release the information requested on the attached insurance claim form.

Signature _____ **Date** _____

I hereby assign and authorize payment of all benefits directly to the [AGENCY NAME].

Signature _____

Notice to Insurer:
Please make all checks payable to the [**AGENCY NAME]** *and mail to*:

[Agency Name]
[Street Address 1]
[Street Address 2]
[City], CA [ZIP code]

Federal Tax I.D. Number: [Agency Tax ID]

For inquiries, contact the [Agency Billing Office]
- E-mail: [Billing Office/Contact e-mail]
- Phone: [Billing Office phone number]

Verification of In-Kind Source of Income

ON AGENCY LETTERHEAD

Verification of In-Kind Source of Income

Date Given: _____

To: [Agency Name]

Note to In-Kind Provider: *Your name has been given as a source of support for the client listed below. Please complete this form and return it to the Business Office of the clinic listed at the bottom of this form.*

Part I: In-Kind Income Verification

I am currently contributing the items of support indicated below to _____,
(Client Name)

Section A

☐ Housing ☐ Utilities ☐ Food ☐ Clothing ☐ Cash

This is in exchange for services or labor: ☐ Yes ☐ No

I/We have been providing these items since _____.

I/We expect to provide these items until _____.

Section B

I/We provide shared in-kind household expenses: ☐ Yes ☐ No

If yes, please explain the shared arrangement: _____

_____

_____

The total value of household items at the following address:

_____

Housing	Utilities	Food	Clothing	Cash
$_____	$_____	$_____	$_____	$_____

The number of people in the household at the address above is _____

Section C

In-Kind provider's relationship to the client is _____

Part II: Verification of Rent Paid

Rent is paid: ☐ Yes ☐ No. If yes, provide the amount is $_____ per _____.

In-Kind Provider Signature: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone Number (_____) _____ - _____

Please return this completed form within 10 business days of the date shown above to:

Attention: _____ Clinic Name: _____

Address: _____ City: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Verification of In-Kind Source of Income (9/1/2023) - NGA

Confidential Client Information
See Welfare & Institutions Code, Section 5328

Reevaluation Follow-Up Letter

ON AGENCY LETTERHEAD

Reevaluation Follow-up Letter

Date: _____

Client Name: _____ **DMH Client ID #:** _____

The Los Angeles County Department of Mental Health and its contracted providers are required by the State of California to charge clients or the financially responsible party for services based on their ability to pay.

All clients are required to complete an annual reevaluation so we can accurately confirm and collect the payer's information. Our records indicate that you are due for an annual reevaluation. Please contact the financial operations staff at the program where you receive services to set up an appointment for financial reevaluation as soon as possible. If you do not complete your annual reevaluation, you could become responsible for the actual cost of care.

If you have healthcare coverage from Medi-Cal, Medicare, or private insurance, please bring proof of coverage to the appointment. Please also bring documents to provide support of the information discussed in the financial screening appointment such as support for income, assets, and allowable expenses.

Sincerely,

_____

Financial Operations Staff

_____

Financial Operations Staff's Telephone Number

Financial Profile Verification Request

Financial Profile Verification Request

Client Name: _____ **DMH Client ID #:** _____

☐ **Identification – Provide any ONE of the following:**
- Driver's License
- California Identification Card
- Passport
- Any governmental issued identification with a photo
- Other photo ID

Proof of Third Party Benefits
☐ Medi-Cal card (Benefits Identification Card)
☐ Medicare card
☐ Private Insurance card: _____
☐ Additional Private Insurance card: _____

☐ **Lifetime Extended Signature Authorization Form**

☐ **Insurance Authorization and Assignment of Benefits Form**

Proof of Income and Employment for:
☐ Client ☐ Financially Responsible Party ☐ Spouse of Financially Responsible Party

Provide verification of the following:
☐ Pay stubs (most recent 3 pay periods or the last 30 days)
☐ Self-Employment income
☐ In-Kind form
☐ Tax returns
☐ Award letter (Unemployment/Social Security Benefits/Veterans/Worker's Compensation)
☐ Other: _____

Proof of Liquid Asset for:
☐ Client ☐ Financially Responsible Party ☐ Spouse of Financially Responsible Party

Provide verification of the following:
☐ Checking Account ☐ Savings Account ☐ IRA
☐ CD ☐ Market Value of Stocks ☐ Bonds
☐ Mutual Funds

Proof of Allowable Expenses
☐ Court ordered obligations paid monthly ☐ Monthly childcare 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)

Additional Comments

Provide all requested verification at your next visit on: _____

(Failure to comply with the above verification could result in responsibility for the full cost of care)

Financial Screening Verification Checklist – English (Rev 9/1/2023)

Automated Eligibility Verification System Response Log

aev trn 1 form
1

Automated Eligibility Verification System (AEVS) Response Log

Page updated: August 2020

Transaction Type:

☐ Eligibility Verification
☐ Share of Cost (SOC)
  ☐ spend down
  ☐ reversal
☐ Medi-Service
  ☐ reservation
  ☐ reversal

Information Entered:

Beneficiary ID #: _____

Date of Birth: _____
(mm/yyyy)

Date of Service: _____
(mm/yyyy)

Procedure Code: _____ (SOC or Medi-Service)

Billed Amount: $_____ (SOC only)

Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____

Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____

Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____

Part 1 – AEVS: Transaction (PRO Pubs)

aev trn 1 form
2
Page updated: August 2020

Response from the Network:

Beneficiary Name: _____

County Code: _____

Primary Aid Code: _____

1st Special Aid Code: _____

2nd Special Aid Code: _____

Message(s): _____
_____
_____
_____

Share of Cost (if any):

$_____ Case #: _____ SOC: $_____
Case #: _____ SOC: $_____
Case #: _____ SOC: $_____

Medicare Coverage: ☐ Part A ☐ Part B Medicare ID #: _____

Other Health Insurance Coverage code: _____

Scope of Coverage (select those which apply):

- ☐ V
- ☐ P
- ☐ L
- ☐ O
- ☐ I
- ☐ M
- ☐ Comprehensive

Eligibility Verification Confirmation Number: _____

Today's Date: _____

Transaction performed by: _____

(This Form Is For Your Records Only)

Part 1 – AEVS: Transaction (PRO Pubs)

https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=aevtrn1form.pdf

Glossary & Acronyms

Glossary

Actual Cost of Care The actual cost of delivering services to the client.
Adjusted Gross Income The total family monthly income plus the value of liquid assets less allowable expenses: Income + Assets – Expenses = Adjusted Gross Income
AEVS The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers the ability to access Medi-Cal subscriber eligibility information through a touch-tone telephone.
Allowable Deductions Court ordered obligations paid monthly for child support or alimony, monthly childcare payments necessary for employment, monthly medical expenses, and mandatory deductions from gross monthly income for retirement plans (not including Social Security).
Annual Charge Period Also known as the Annual Liability Period, the Annual Charge Period is a 12-month period that constitutes the client's fiscal year. The annual charge period is 365/366 days long and can start on any day in the month.
Annual Liability Amount The most a client is responsible to pay for services for an entire year. The annual liability is from a sliding scale. The annual liability is a fee that applies to services extended to the client and dependent family members.
Annual Liability Period Also known as the Annual Charge Period, the Annual Liability Period is a 12-month period that constitutes the client's fiscal year. The annual liability period is 365/366 days long and can start on any day in the month.
BIC The Benefits Identification Card (BIC) is issued to Medi-Cal beneficiaries by the California Department of Health Care Services (DHCS).
Cal ID # Identification number listed on a client's state-issued California Identification card used to prove identity or age.
CalWORKs California Work Opportunity and Responsibility to Kids (CalWORKs) – California's welfare-to-work program administered by DPSS that provides temporary financial assistance and employment focused services to families with minor children that have income and property below State maximum limits from their family size. Providers must have a referral from DPSS to deliver CalWORKs services to clients.

CHAMPVA The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health insurance program in which the VA shares the cost for healthcare services and supplies with their eligible beneficiaries. Generally, CHAMPVA beneficiaries are limited to spouses, widow/er(s), and children of qualifying Veterans. For more information, please visit the VA's CHAMPVA website.
Client Index Number – CIN The Client Index Number is the first nine characters of the Identification number located on the front of the Medi-Cal beneficiary's Benefits Identification Card (BIC).
Court Ordered Obligations A sum of money that is ordered by a superior court for legal financial obligations.
DPSS The Los Angeles County Department Public Social Services (DPSS) assists low-income individuals and families with Medi-Cal and other social services programs.
EVC # Eligibility Verification Confirmation (EVC) Number – Providers verify Medi-Cal eligibility on the Medi-Cal website, POS device, AEVS, or using Real Time (270). The EVC # is a 10-character number that is returned in the response when the client is eligible for Medi-Cal on the service date.
FICA Federal Insurance Contributions Act (FICA) – A U.S. federal payroll tax that is deducted from each paycheck to fund Social Security and Medicare.
Financially Responsible Person Client's spouse, parent of a minor, a guardian/conservator, or legal representative of a client's estate that would be the financially responsible to provide information to the financial operations staff assessing the ability to pay for services.
GR General Relief (GR) – Temporary cash assistance administered by DPSS.
Gross Income Total family income before taxes and deductions are subtracted.
GROW General Relief Opportunities for Work (GR) – A program administered by DPSS that provides General Relief (GR) customers with training and employment services to help eliminate the need for GR benefits.
HMO Health Maintenance Organization (HMO) – A type of healthcare plan that manages health care and provides coverage for services to its members. Usually limits payment to providers within their network.
IBHIS Integrated Behavioral Health Information System – The electronic health record and claiming system of the Los Angeles County Department of Mental Health (DMH).

In-Kind Income A source of income or support when a client receives housing, utilities, food, clothing, and/or cash from another person, other than a responsible relative, without incurring financial liability.
Liability Adjustment A change made to a client's annual liability due to a change in the client's or responsible party's financial circumstances or health coverage.
Liquid Assets Any financial instrument that can easily be converted into cash in a short amount of time (i.e., IRAs, 401Ks, market value stocks, and/or savings bonds).
Managed Care Plan A type of health care network focused on providing care at a reduced cost while keeping the quality of care high.
MBI Medicare Beneficiary Identifier – Medicare policy number consisting of 11 alpha-numeric characters. The MBI replaced the Health Insurance Claim Numbers (HICN), used for eligibility verification, claim submissions, and appeals.
Medi-Cal California's public health insurance program funded by federal and State taxes, cover a variety of medical services for children and adults with limited income and resources.
Medi-Cal Aid Code A 2-character code that indicates whether the client is a Medi-Cal beneficiary. The aid code indicates the program under which the client became eligible for Medi-Cal. Benefits represented by the aid code can be full scope, restricted, or restricted/limited Medi-Cal.
Medi-Cal County Code A 2-digit code that representing the county a Medi-Cal beneficiary has an approved Medi-Cal case. The code for Los Angeles County is 19.
Medicare A federal health insurance program for people who are aged 65 or older, certain younger people with disabilities, or for those with End-Stage Renal Disease (ESRD).
Medi-Gap A private health insurance policy designed to supplement Medicare benefits by filling in some of the gaps in coverage by providing payment for charges for which Medicare does not have responsibility including deductible, co-payment, prescription drugs, and dental.
MEDS Medi-Cal Eligibility Data System – A California-wide database provides a client's current Medi-Cal eligibility and benefits history.
Monthly childcare payment Monthly expense incurred for necessary childcare as a result of a parent working.
Monthly dependent support payment Monthly expense incurred for dependent support for children, spouse, or parent. Does not include individuals counted as family members when determining the annual liability.

Monthly mandated deductions for retirement plans Amount deducted monthly from gross income for a retirement plan that is a condition of employment and is not elective.
Monthly medical expense payments Monthly costs incurred in the prevention or treatment of a medical injury or disease including, but not limited to, health and dental insurance premiums, co-pay's, prescription drugs, etc.
PFI Payer Financial Information (PFI) form **–** The form used during the financial screening to capture the client's/responsible party's financial and healthcare coverage information to determine the client's ability to pay for mental health services received.
PHP Prepaid Health Plan (PHP or Plan) – A Medi-Cal managed care plan administering Medi-Cal services recipients enrolled in the Plan.
PPO Preferred Provider Organization (PPO) – A network of healthcare providers one utilizes for medical treatment at a lower cost if they visit doctors and hospitals contracted to the organization. Typically, these providers differ from an HMO in that the consumer may also opt to receive healthcare outside the network of contracted providers.
SOC Share of Cost (SOC) – The amount the Medi-Cal recipient is obligated to pay toward their medical expenses each month before they qualify for Medi-Cal assistance for the benefit month.
SSDI Social Security Disability Income (SSDI) – The SSDI program pays benefits to adults, and certain dependents, who have recently paid Social Security taxes on earnings and meet requirements for a qualifying disability expected to last at least (1) year and have limited income or resources.
SSI Supplemental Security Income (SSI) **–** A federal program that provides monthly income to adults aged 65 (or older), blind, or disabled and have income and resources below specific financial limits. Children under the age of 18 who have a physical or mental condition that limits their daily activities for a period of (12) months or more and live in household with limited income and resources also qualify for this program.
TFA Therapeutic Fee Adjustment (TFA) **–** An adjustment to the client's UMDAP annual liability that is based on the opinion of a therapist. The adjustment would be recommended if an update to the client's annual liability would be beneficial to the client's treatment. TFAs need Program Head Approval before an adjustment is made.
Third Party Payer A party other than the client/responsible person or the provider that pays for all or a part of the cost of the client's care. Third-party payers are usually an insurance company or other organization that provides medical services or healthcare coverage.

TRICARE Uniformed services healthcare program for active-duty service members, retirees, their dependents, and survivors. Formerly known as CHAMPUS. TRICARE is not an acronym. For more information, see the Military Health System's TRICARE Web site.
UMDAP Uniform Method of Determining Ability to Pay (UMDAP) – The method used for determining the client's ability to contribute to paying for the services rendered by providers operated by or contracted with County Mental or Behavioral Health departments throughout California.
VA Veteran's Administration (VA) – Provides medical care, benefits, and essential services to veterans of the U.S. armed forces and their families.

Acronyms

An acronym is formed from the first letters of several words. At DMH, other county departments, State, and Federal government will often use acronyms in everyday conversation. Use this list of acronyms as a guide to the most commonly used acronyms in the Financial Screening Manual.

Acronym	Meaning
AEVS	Automated Eligibility Verification System
BIC	Benefits Identification Card
CalWORKs	California Work Opportunity and Responsibility to Kids
CBO	Central Business Office
CD	Certificate of Deposit
CDL	California Driver License
CGF	County General Funds
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CIN	Client Index Number
DHCS	California Department of Health Care Services
DMH	Los Angeles County Department of Mental Health
DO	Directly Operated
DPSS	Los Angeles County Department of Public Social Services
EVC #	Eligibility Verification Confirmation Number
FCC	Full Cost of Care
FICA	Federal Insurance Contributions Act
FOA	Financial Obligation Agreement
GR	General Relief
GROW	General Relief Opportunities for Work
HCP	Health Care Providers
HMO	Health Maintenance Organization
IAAB	Insurance Authorization and Assignment of Benefits
IBHIS	Integrated Behavioral Health Information System
IRA	Individual Retirement Account
LE	Legal Entity
LESA	Lifetime Extended Signature Authorization
MBI	Medicare Beneficiary Identifier
MEDS	Medi-Cal Eligibility Data System
NGA	Non-Governmental Agency
NPI	National Provider Identifier
OHC	Other Health Coverage or Other Healthcare Coverage

Acronym	Meaning
PCP	Primary Care Physician
PFFS	Private Fee for Service
PFI	Payer Financial Information
PHP	Prepaid Health Plan
POS	Point of Service Device
PPO	Preferred Provider Organization
PTAN	Provider Transaction Access Number
SAL	Systemwide Annual Liability
SOC	Share of cost
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TFA	Therapeutic Fee Adjustment
UMDAP	Uniform Method of Determining Ability to Pay
VA	Veterans Administration