CBO Bulletin

Issue No.: NGA 23-014R
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PAYER FINANCIAL INFORMATION FORM (MH-281) UPDATED

The California Department of Health Care Services requires the collection of reimbursement for services from private or public third-party payers and from clients, as appropriate (Welfare and Institutions Code 5872). Clients receiving mental health services must be financially screened to determine their ability to pay for services. Providers operated by or contracted with the Los Angeles County Department of Mental Health (DMH) use the Payer Financial Information (PFI) form to fulfill these requirements.

This Bulletin is to announce that the PFI has been updated. Outdated information has been removed to make room for new fields that will allow users to capture information regarding special client populations and third-party payers. Below is a list of some of the changes made to each part of the PFI.

PFI Part	Lines/Boxes	Description of Changes
Client Information	1-4	✎ Added Family Registration field ✎ Added row to identify Special Populations ✎ Moved Provider of Financial Information field to the top of the form
Third-Party Information	5-11	✎ Removed fields for AB3632, CalWORKs, HWLA ✎ Added field for ECM Plan Name ✎ Added rows to document another private insurance ✎ Added fields to note that insurance coverage is Medicare Advantage
Payer References	12-20	✎ Updated ID field to allow for other forms of identification
UMDAP Liability Determination	Boxes 21-23, Line 24	✎ Changed Box numbers ✎ Clarified label for Number Dependent on Income
Other	25-28	✎ Updated Reason Adjusted field for adjustments to the annual liability ✳ Added checkboxes for TFA and Other reasons ✳ Added instruction to enter the date the client signed the TFA in the Reason Adjusted field

Detailed instructions on completing the revised PFI are provided in the updated Financial Screening Manual. The revised PFI is dated September 1, 2023. The updated Financial Screening Manual scheduled to be released in the coming weeks will have an October 1, 2023, revision date.

The PFI is available for use as of the date of this Bulletin. Begin using this revision for all clients needing an initial financial screening or reevaluation on or after September 1, 2023. Agencies integrating the PFI into their Electronic Health Record (EHR) or claiming system must have the form available for use no later than January 1, 2024. Clients who have a current PFI on file will not need to have their form updated until the expiration of their current annual charge period or until the client has experienced financial or insurance changes that require a review of their annual liability.

Please note, signatures on the PFI can be written out by hand, electronic, or digital. Verbal consent is not allowed on the PFI or any financial form.

An image of the new PFI is below. A fillable version of the revised PFI is attached to this Bulletin and will be posted online with Central Business Office (CBO) Bulletins: Central Business Office (CBO) Bulletins - Department of Mental Health (lacounty.gov).

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

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	$ 0.00	Monthly medical expense payments	$	TOTAL HOUSEHOLD INCOME	$ 0.00
Less Asset Allowance	$	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$	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** 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