## LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

CONFIDENTIAL CLIENT INFORMATION

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POUSE'S EMPLOYER					ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #		
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IEAREST RELATIVE/RELATIONSHI	P		ADDRESS (Include City, State & Zip Code)					TEL#		
IDAP LIABILITY DETE	RMINATION							<u> </u>		
21 LIQUID	ASSETS	22	ALI	LOWABLE	EXPENSES	23 ADJUSTED MONTHLY INCOME				
	rt.		rt ordered obli		_	CROS	C MONITUU	VINICOME		
avings	\$	I '	monthly		\$	Self/Pa	S MONTHL' ayer		\$	
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RA, CD, Market value of	\$		loyment) thly dependen	nt	Φ.	Other			\$	
tocks, bonds and mutual unds		supp	ort payments		<b>D</b>		HOUSEHO	OLD	\$	
TOTAL LIQUID ASSETS \$			thly medical ex nents	xpense	\$	INCOM		V 21 -	<b>.</b>	
.ess Asset Allowance \$		Mont	thly mandated		TOTAL FROM BOX 21 + \$  SUBTOTAL + \$					
			uctions from gr me for retireme		\$			+ :	<b>\$</b>	
Net Asset Valuation \$			plans. (Do not include Social Security)			LESS TOTAL FROM BOX 22 - \$				
Monthly Asset Valuation (Divide Net Asset by 12) \$			Total Allowable Expenses \$			Adjusted Monthly Income \$				
VERIFICATION OBTAINED YES NO			VERIFICATION OBTAINED YES NO			VERIFICATION OBTAINED ☐ YES ☐ NO				
lumber Dependent on Adjuste Ionthly Income (Client included		BILITY	Al	NNUAL CH	IARGE PERIOD	F	Payment P	lan \$	per mont	
			FROM		_то	f	or <u> </u>	2 🗆 3 🗆 4 🗆 5	<u>5 □6</u> month	
FHER  PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIC  ☐ YES ☐ NO WHERE:					FROM	ТО		CURRENT ANNU	JAL LIABILITY BALANCE	
ANNUAL LIABILITY ADJUSTED BY					DATE	REASON ADJUSTED ☐ TFA (enter date client signed below)				
ANNUAL LIABILITY ADJUSTMENT APPROVED BY					DATE	☐ Other (describe below)				
An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER						PROVIDER NAME AND NUMBER				
	ζ							d on line 24		

患者機密情報 支払者財務情報 患者情報 W&Iコード、セクション 5328 をご覧ください 社会保障番号 DMH(精神衛生局)患者 ID 番号 家族登録番号 配偶者/パートナー/大切な人の氏名 旧姓 生年月日 婚姻状況 2 □既婚 □未婚 □離婚 □ 離別 □死別 里親制度 犯罪被害者 退役軍人 労災保険 ホームレス CALWORKS (カリフォルニア その他の特別対応者: 口はい 口いいえ 州における公的扶助制度) 口はい 口いいえ 口はい 口いいえ 口はい 口いいえ 口はい 口いいえ 3 口はい 口いいえ 財務情報の提供者氏名および住所(患者または責任者以外の場合のみ記入) Δ 第三者情報 HEALTHY FAMILIES MEDI-CAL ECM プラン名 MEDI-CAL 郡コード/AID コード/CIN 番号 費用負扣 社会保険 MEDI-CAL 保留 5 口はい 口いいえ □はい □いいえ 口はい 口いいえ Ś はい 口いいえ MEDI-CAL/SSI(補足的所得補償)対象者が給付査定に紹介されなかった理由 SSI(補足的所得補償)申請 給付査定のための紹介 SSI(補足的所得補償) □はい □いいえ 紹介日 6 保留 □はい □いいえ MEDICARE MEDICARE 番号(MBI) 署名による承認の終身継続 承認署名済み MEDI-GAP TRICARE CHAMPVA(退役軍人 口はい 口いいえ 口はい 口いいえ 口はい 口いいえ 局プログラム) 7 口はい 口いい 署名日 □はい □いいえ 保険会社名 契約者ポリシーID 番号 MEDICARE ADVANTAGE 契約者名 HMO / PPO 8 □はい □いいえ 口はい 口いいえ 精神医療請求のための保険会社住所 保険承認および署名済みの給付金受給権譲渡書□はい□いいえ 9 保険会社名 契約者ポリシーID 番号 契約者名 MEDICARE ADVANTAGE ADD'L HMO / PPO 10 □はい □いいえ □はい □いいえ 精神医療請求のための保険会社住所 保険承認および署名済みの給付金受給権譲渡書 □はい □いいえ 支払者照会先(患者または経済的責任者) 支払者氏名 患者との関係 牛年日日 婚姻状況 支払者 CDL/CAL ID/その他の ID 12 □既婚 □未婚 □離婚 □離別 □死別 支払者の住所 電話番号 13 収入源: □給与 □自営業 □失業保険 □障害保険 支払者社会保障番号 14 □ SSI (補足的所得補償) □ GR □ VA □ その他の公的扶助 □ 現物 □ 不明 □ その他: 無職の場合、最終勤務日 15 雇用者の住所(市・州・郵便番号を含む) 雷話番号 16 配偶者 住所(市・州・郵便番号を含む) 配偶者の社会保障番号 17 配偶者の雇用者 役職 無職の場合、最終勤務日 18 配偶者の雇用者の住所(市・州・郵便番号を含む) 雷話番号 19 最も近い親族/関係 電話番号 住所(市・州・郵便番号を含む) 20 UMDAP 責任判定 流動資産 許容経費 調整後月収 21 22 23 総月収 貯金 裁判所命令による月々の支払 本人/支払者 預金口座 保育にかかる月々の支払い( 配偶者 IRA、CD、株式・債券・投資 就業に必要なもの) 信託の時価総額 その他 家族の扶養にかかる月々の支 世帯収入合計 総流動資産 ボックス 21 の合計 月々の医療費の支払い 資産控除 総収入から退職年金への月々 の必須控除(社会保障は含ま 純資産評価額 ボックス 22 の合計を差し引いたもの- \$ ない) 毎月の純資産評価額 許容経費の合計 調整後日収 Ś (純資産を 12 で割ったもの) 確認済 口はい 口いいえ □はい □ いいえ 確認済 口はい 口いいえ 確認済 調整後月収による人数(患者を含 支払いプランS /月 年間責任負担額 年間請求期間 24 **đ**:)  $\Box$ 1  $\Box$ 2  $\Box$ 3  $\Box$ 4  $\Box$ 5  $\Box$ 6 まで 月分 その他 開始日 終了日 現在の年間責任負担残額 現在の年間請求期間中に過去受けた精神保健治療 □あり □なし 受けた場所: 調整理由 ロTFA(以下に患者署名日を記入) ロその他(以下に記述) 年間負担調整額 日付 26 年間負担調整承認額 日付 UMDAP 責任について説明がありました。 説明者名および番号 27 担当者の罢名 ここに記載された内容は、私の知る限り真実かつ正確であることを認め、24 行目に記載された支払計画に同意します。 患者の署名 または経済的責任者の署名 日付