## LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

CONFIDENTIAL CLIENT INFORMATION

SSI PENDING SSI APPLIC PENDING SSI APPLIC SSI PENDING MEDICARE PENDING MEDICARE M	TION  AN NAME MED  CATION DATE REI  NUMBER (MBI) LIFE NAME  ADVANTAGE NAME  ADVANTAGE NAME  ADVANTAGE NAME  ALARY SELF EMP  her Public Assistance	PLOYED I	RESPONSI RELATION T CITY  UNEMPLOY	HOMELESS YES NO	PEALTHY FAMIL    HEALTHY FAMIL   YES   NO   REASON FOR NO   SUBSCRIBER POL   SUBSCRIBER POL   SUBSCRIBER POL	OTHER SPE  IES SHARE O YE  REFERRING I  O ME YE  CYID#  INSUR BENEI  CYID#  INSUR BENEI  MARIT M S  STATE	CIAL POPU  COF COST S NO MEDI-CAL/SS  DI-GAP S NO SUBSCRIBER ANCE AUT FITS SIGNA' SUBSCRIBER ANCE AUT	SOC AMT \$ SOC AMT \$ ITRICARE YES NO R NAME  HORIZATION 8 TURES OBTAIN R NAME  HORIZATION 8 TURES OBTAIN R NAME	MEDI-CAL PENDIN  YES NO NEFITS ASSESSMENT  CHAMPVA	
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MPLOYER'S ADDRESS (Include C	ty, State & Zip Code)			. 03/11010				IF NOT EMPLO	YED, DATE LAST	
POUSE	ty, state a zip code,				'		WORKED TEL#			
			1000000 // L	1 0: 0:	0.7: 0.1.)					
POUSE'S EMPLOYER		SPOUSE ADDRESS (Include City						SPOUSE'S SS #		
SPOUSE'S EMPLOYER PC					l			IF NOT EMPLOYED, DATE LAST WORKED		
POUSE'S EMPLOYER'S ADDRESS	(Include City, State & Zip	Code)		•				TEL#		
NEAREST RELATIVE/RELATIONSHIP ADDRESS (Incl					& Zip Code)		TEL#			
IDAP LIABILITY DETE	RMINATION							<u> </u>		
1 LIQUID ASSETS			22 ALLOWABLE EXPENSES			23 ADJUSTED MONTHLY INCOME				
			rt ordered obli		_	CROS	GROSS MONTHLY INCOME			
Checking Accounts \$		I '	monthly		\$	Self/Pa		\$		
		payn	thly childcare nents (necessa	ry for	\$	Spous	е		\$	
IRA, CD, Market value of \$ stocks, bonds and mutual funds			loyment) thly dependen	nt	Φ.	Other	Other \$			
			ort payments		<b>D</b>	TOTAL HOUSEHOLD \$				
TOTAL LIQUID ASSETS \$			thly medical ex nents	xpense	\$	INCOM	<b>.</b>			
Less Asset Allowance \$			thly mandated			TOTAL FROM BOX 21 + \$				
Net Asset Valuation \$  Monthly Asset Valuation (Divide Net Asset by 12) \$			uctions from gr me for retireme	\$	SUBTO		+ :	<b>\$</b>		
			plans. (Do not include Social Security)  Total Allowable Expenses			LESS TOTAL FROM BOX 22 - \$				
						Adjus	ted Monthl	ly Income	\$	
ERIFICATION OBTAINED	YES NO		IFICATION C		☐ YES ☐ NO				☐ 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	
HER RIOR MENTAL HEALTH TREA  YES NO WHERE:	TMENT DURING CUR	RRENT AN	NUAL CHARGI	E PERIOD	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		

ī	1객 정보	결제자 금융 정보			복지 및 기관법(W & I Code), 5328 조 참조								
1	고객 성명	사회보장번호				정신건	건강부(DMI	1) 고객 ID 변	호	가족 등록 번호			
2	결혼 전 성	Ş	뱅년월일	□기혼(M) <b>□</b>	인 상태 ]미혼(S) □이혼(D) W) □별거(SP)	배우지	배우자/파트너/동반자의 성명						
3	양육 관리 여부 범죄 피해자 여부 참전 용사 여부 미예 미아니요 미예 미아니요 미예 미아니요	□ 0			부 CALWOR			타 특별 인	구:				
4	4 금융 정보 제공자 성명 및 주소(고객 또는 책임자가 <u><b>아년</b></u> 경우에만 작성)												
7.	∥삼자 정보												
5	□ 있음 □ 없음		베이드 코드 / CIN # 를 위한 의뢰		(HEALTHY FAMIL ໄ음 ロ없음 MEDI-CAL/SSI 에서		비용분[	아니요	SOC AN	MT MEDI-CAL 보류 여부 <b>미예 미</b> 아니요			
6	00. — 11		를 위한 의되 의뢰 일자		MEDI-CAL/SSI MIA	기예백 E	3여 평가들	의되아시 6	ᡩ는 시규				
7	메디케어(MEDICARE) MEDICARE 번호(MBI) 평생 연간 마이 의 의 의 의 의 의 의 의 의 의 의 의 의 의 의 의 의 의		응인서에 서명 여부 서명 일자		메디갭(MEDI-0 ㅁ있음 ㅁ없			이케어(TRI 있음 ㅁ1		재향 군인회 민간인 건강 및 의료 프로그램(CHAMPVA) □ 있음 □ 없음			
8	HMO/PPO 메디케어 어드밴티지(MEDICARE ADVANT/ □ 있음 □ 없음 □ 있음 □ 없음	11 1 1 1 1 2 1 1(================================						증권 ID 번호 가입자명					
9	정신 건강 청구용 보험사 주소	<i>m</i> =					│ │ │ │   						
10	추가 HMO/PPO 메디케어 어드밴티지(MEDICARE ADVANTA	(GE) 보험	사명	가입자 보험 증권 ID 번호 가입자명			입자명						
11	정신 건강 청구용 보험사 주소	I			보험 승인 및 혜	택 할당	서명 취득	특 여부 □	있음 🗆 🏻	, , , , , , , , , , , , , , , , , , , ,			
	를제 추천인(고객 또는 재정 책임자)												
12	결제자 성명	고객과의 관계		생	생년월일 C		혼인 상태 ]기혼(M) □미혼(S) □이 □ 사별(W) □별거(SP		결제자 CDL/CAL ID/기타 ID E(D)				
13	결제자 주소		시	I		주		크는 ((Si / 편번호	전회	·번호			
14	수입원: □급여 □자영업 □실업보험 □장애보 □SSI □ GR □VA □기타공공지원 □현물보조		수 없음 □기타	:			 		결제자 사호	·			
15	고용주		2	딕위				고용되어	거 있지 않은	경우, 마지막으로 근무한 날짜			
16	고용주 주소(도시, 주 및 우편번호 포함)								전화번호				
17	배우자 주소(도시, 주 및 우편번호 포함)						배우자 사회보장번호						
18	배우자의 고용주					직위				고용되어 있지 않은 경우, 마지막으로 근무한 날짜			
19	배우자의 고용주 주소(도시, 주 및 우편번호 포함)						전화번호						
20	가장 가까운 친척/인척	2	주소(도시, 주 및 우편번호 포함)						전화번호				
Ų	IMDAP 책임 결정												
	21 유동 자산	22 허용 비용			3		23		조정	된 월 소득			
	저축예금 \$	법원 명령에 따라 매월 지급되는					월 총수입 본인/결계			¢			
	당좌예금 \$		의무 금액 \$ 의병 변 의 지금에(금의 세				바우자 \$						
	IRA, CD, 주식, 채권 및 뮤추얼 펀드의 시장 가치 \$	궐일 노 필요)	!별 보육비 지급액(고용 시 !요) \$				 기타	\$					
	*************************************	월별 부	월별 부양가족 지원 금액 \$				총가구소득 \$						
	자산 충당금 감액 \$	월별 으	의료비 지급액 \$				21 번 상자의 합계 \$						
	순자산 가치 평가 \$	에서 느 글애	소계			·							
	월간 자산 평가액 (순자산을 12 로 나눔) \$	매월 의무적으로 공제되는 금액 (사회보장 연금은 포함되지 않음) \$ 총허용비용 \$					22 번 상자의 합계 차감 \$ <b>조정된 월 소득</b> \$						
	빙획득유무 □예 □아니요 증빙획득유무 □예				□ 아니요			증빙 획득 유무 □예 □ 아니요					
24	조정된 월 소득으로 부양하는 가족 <b>연간 책임</b> 수(고객 포함)			연간 청구 <sup>부터</sup>	·기간	까지		∥ 예정 매 □2 □3	월 \$ <u>□4</u> □5	<u> </u>			
7	l타												
25	현재 연간 청구 기간 내 사전 정신건강 치료  □ 있음 □ 없음 장소:			시작		종			현재 연간 부				
26	연간 부채 조정 연간 부채 조정 승인		일자			TFA □조정 사유(아래에 고객 서명 일자 입력) □ 기타(아래에 설명)							
27	UMDAP 책임에 관한 설명을 들었습니다. 면접관 서명			설명 자 성명 및 번호									
28	본인은 여기에 기재된 진술이 본인이 아는 한 진실하고 정 고객 서명	확함을 획	확인하며 24 번 줄(	에 명시된 결	제 계획에 동의합	<u> </u> 합니다							
	또는 재정 책임자의 서명					날짜							