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

Savings	$_____
Checking Accounts	$_____
IRA, CD, Market value of stocks, bonds and mutual funds	$_____
TOTAL LIQUID ASSETS	$0.00
Less Asset Allowance	$_____
Net Asset Valuation	$0.00
Monthly Asset Valuation (Divide Net Asset by 12)	$0.00

VERIFICATION OBTAINED ☐ YES ☐ NO

22 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)	$_____
Total Allowable Expenses	$0.00

VERIFICATION OBTAINED ☐ YES ☐ NO

23 ADJUSTED MONTHLY INCOME

GROSS MONTHLY INCOME Self/Payer	$_____
Spouse	$_____
Other	$_____
TOTAL HOUSEHOLD INCOME	$0.00
TOTAL FROM BOX 21 +	$0.00
SUBTOTAL +	$0.00
LESS TOTAL FROM BOX 22 -	$0.00
Adjusted Monthly Income	$0.00

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	