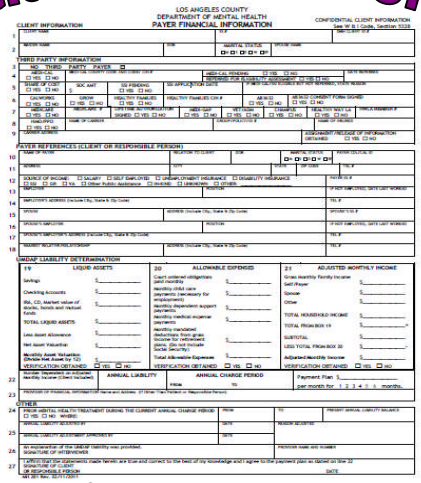
RMD Bulletin

Knowledge is power…

Revised Payer Financial Information (PFI) Form


LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
PAYER FINANCIAL INFORMATION

CLIENT INFORMATION

THIRD PARTY INFORMATION

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

MEDI-CAL LIABILITY DETERMINATION

19 LIQUID ASSETS

20 ALLOWABLE EXPENSES

21 ADJUSTED MONTHLY INCOME

OTHER

MH-281

The State Department of Mental Health mandates that each client treated in the county mental health care system be financially screened to determine the client's ability to pay for the mental health services received.* In addition, Welfare and Institutions Code (WIC) Section 5872 states that all participating counties shall collect reimbursement for services from fees paid by private or public third party payers. The Los Angeles County Department of Mental Health uses the Payer Financial Information (PFI) form (MH281) to meet these regulatory requirements.

Revenue Management Division (RMD) has updated the PFI form to include additional Third Party Payer fields to maximize the information attained. The revised form is attached to the end of this Bulletin and is available online at http://lacdmh.lacounty.gov/hipaa/documents/PFI_Rev20110211.pdf.

Providers must now begin using the updated PFI (Revised 02/11/2011) for all new clients and clients who are due for reevaluation. The current PFI on file is still valid for the current annual charge period until the expiration date. There is no need to update the client's current PFI using the revised form unless changes have occurred during the client's annual charge period.

* WIC Sections 5709 and 5710 and California Code of Regulations (CCR), Title 9, Division 1, Subchapter 3, Article 3, Section 524.

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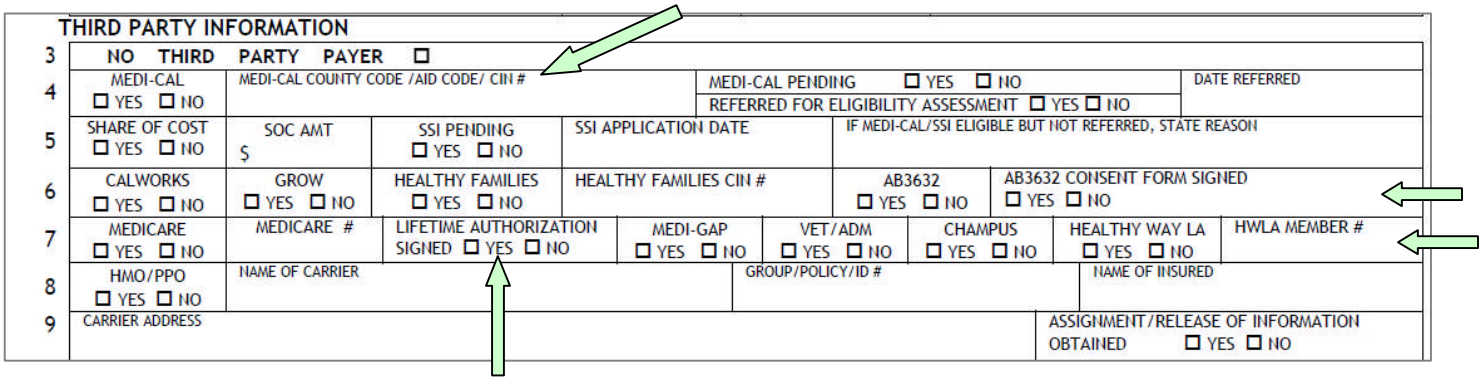
The new and revised Third Party Information fields are as follows:



THIRD PARTY INFORMATION

3 NO THIRD PARTY PAYER ☐

4 MEDI-CAL ☐ YES ☐ NO | MEDI-CAL COUNTY CODE /AID CODE/ CIN # | MEDI-CAL PENDING ☐ YES ☐ NO; REFERRED FOR ELIGIBILITY ASSESSMENT ☐ YES ☐ NO | DATE REFERRED

5 SHARE OF COST ☐ YES ☐ NO | SOC AMT $ | SSI PENDING ☐ YES ☐ NO | SSI APPLICATION DATE | IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON

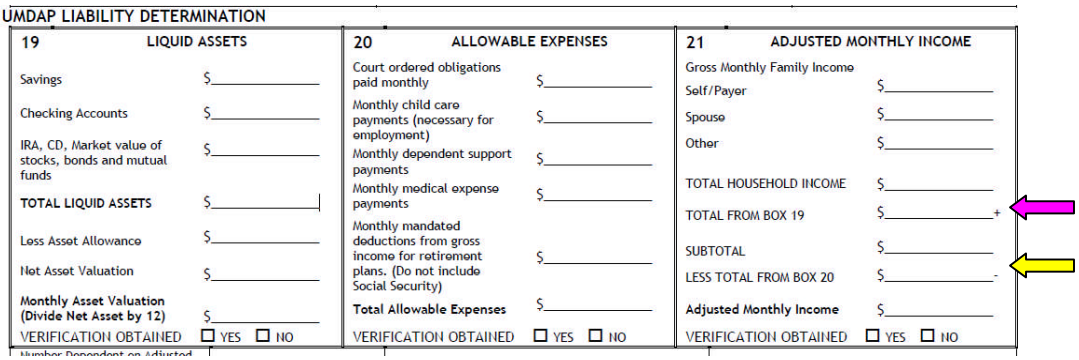
6 CALWORKS ☐ YES ☐ NO | GROW ☐ YES ☐ NO | HEALTHY FAMILIES ☐ YES ☐ NO | HEALTHY FAMILIES CIN # | AB3632 ☐ YES ☐ NO | AB3632 CONSENT FORM SIGNED ☐ YES ☐ NO

7 MEDICARE ☐ YES ☐ NO | MEDICARE # | LIFETIME AUTHORIZATION SIGNED ☐ YES ☐ NO | MEDI-GAP ☐ YES ☐ NO | VET/ADM ☐ YES ☐ NO | CHAMPUS ☐ YES ☐ NO | HEALTHY WAY LA ☐ YES ☐ NO | HWLA MEMBER #

8 HMO/PPO ☐ YES ☐ NO | NAME OF CARRIER | GROUP/POLICY/ID # | NAME OF INSURED

9 CARRIER ADDRESS | ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO

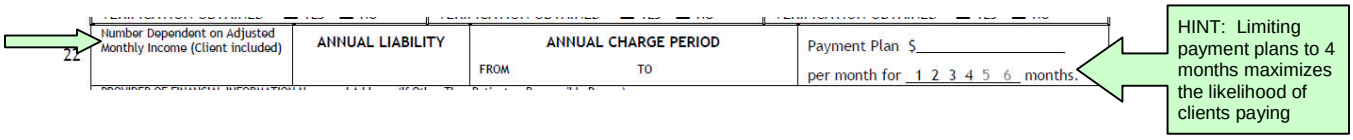
The New UMDAP Liability Determination tally instruction for box 21:



UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS		20 ALLOWABLE EXPENSES		21 ADJUSTED MONTHLY INCOME	
Savings	$	Court ordered obligations paid monthly	$	Gross Monthly Family Income	
Checking Accounts	$	Monthly child care payments (necessary for employment)	$	Self/Payor	$
IRA, CD, Market value of stocks, bonds and mutual funds	$	Monthly dependent support payments	$	Spouse	$
TOTAL LIQUID ASSETS	$	Monthly medical expense payments	$	Other	$
Less Asset Allowance	$	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$	TOTAL HOUSEHOLD INCOME	$
Net Asset Valuation	$	Total Allowable Expenses	$	TOTAL FROM BOX 19	$ +
Monthly Asset Valuation (Divide Net Asset by 12)	$	VERIFICATION OBTAINED ☐ YES ☐ NO		SUBTOTAL	$
VERIFICATION OBTAINED ☐ YES ☐ NO				LESS TOTAL FROM BOX 20	$ -
				Adjusted Monthly Income	$
				VERIFICATION OBTAINED ☐ YES ☐ NO	

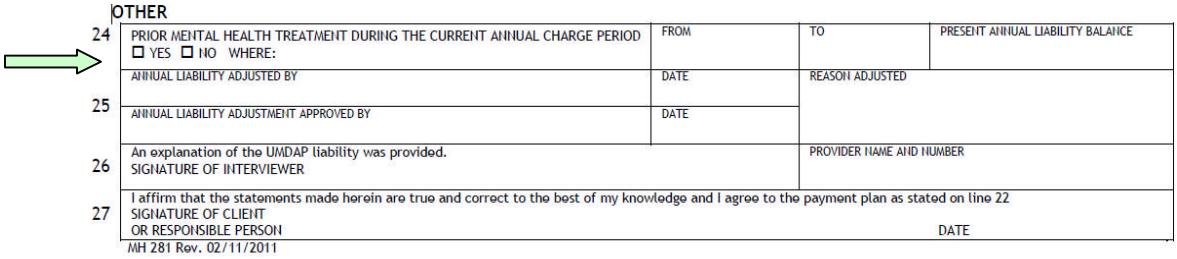
The New changes for Line 22:



22 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.

HINT: Limiting payment plans to 4 months maximizes the likelihood of clients paying

New changes under OTHER:



OTHER

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

ANNUAL LIABILITY ADJUSTED BY | DATE | REASON ADJUSTED

25 ANNUAL LIABILITY ADJUSTMENT APPROVED BY | DATE

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

27 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 22
SIGNATURE OF CLIENT OR RESPONSIBLE PERSON | DATE

MH 281 Rev. 02/11/2011

Remember, clients who refuse to provide financial information are responsible for the full cost of care. Let the client know that when they provide the required information, they may be responsible for only a portion of the actual cost.

As always, if another provider has completed a PFI and has established a current Uniform Method of Determining Ability to Pay (UMDAP) annual liability and that information is available in the Integrated System (IS), then the current provider may complete a PFI with the information obtained from the IS. Retain the current annual UMDAP liability period, and indicate on the PFI that the information was obtained from the IS.

We're here to help you…

If you have any questions or require further information, contact RMD at (213) 480-3444 or via e-mail at RevenueManagement@dmh.lacounty.gov.

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 #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE NAME

THIRD PARTY INFORMATION

3 ☐ NO THIRD PARTY PAYER

4	MEDI-CAL ☐ YES ☐ NO	MEDI-CAL COUNTY CODE /AID CODE/ CIN #		MEDI-CAL PENDING ☐ YES ☐ NO REFERRED FOR ELIGIBILITY ASSESSMENT ☐ YES ☐ NO				DATE REFERRED
5	SHARE OF COST ☐ YES ☐ NO	SOC AMT $	SSI PENDING ☐ YES ☐ NO	SSI APPLICATION DATE	IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON			
6	CALWORKS ☐ YES ☐ NO	GROW ☐ YES ☐ NO	HEALTHY FAMILIES ☐ YES ☐ NO	HEALTHY FAMILIES CIN #	AB3632 ☐ YES ☐ NO	AB3632 CONSENT FORM SIGNED ☐ YES ☐ NO		
7	MEDICARE ☐ YES ☐ NO	MEDICARE #	LIFETIME AUTHORIZATION SIGNED ☐ YES ☐ NO	MEDI-GAP ☐ YES ☐ NO	VET/ADM ☐ YES ☐ NO	CHAMPUS ☐ YES ☐ NO	HEALTHY WAY LA ☐ YES ☐ NO	HWLA MEMBER #
8	HMO/PPO ☐ YES ☐ NO	NAME OF CARRIER		GROUP/POLICY/ID #		NAME OF INSURED		
9	CARRIER ADDRESS					ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO		

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

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

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS

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

VERIFICATION OBTAINED ☐ YES ☐ NO

20 ALLOWABLE EXPENSES

Court ordered obligations paid monthly	$_____
Monthly child care 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	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

21 ADJUSTED MONTHLY INCOME

Gross Monthly Family Income	
Self/Payer	$_____
Spouse	$_____
Other	$_____
TOTAL HOUSEHOLD INCOME	$_____
TOTAL FROM BOX 19	$_____ +
SUBTOTAL	$_____
LESS TOTAL FROM BOX 20	$_____ -
Adjusted Monthly Income	$_____

VERIFICATION OBTAINED ☐ YES ☐ NO

22	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.		
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)		

OTHER

24	PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
27	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 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON		DATE	