LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

PAYOR FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1	CLIENT NAME	SS #		CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐ M ☒ S ☐ D ☐ W ☐ SP	SPOUSE NAME

THIRD PARTY INFORMATION

3	NO THIRD PARTY PAYOR ☐					
4	MEDI-CAL ☐ YES ☐ NO	MEDI-CAL COUNTY CODE /AID CODE/ CLAIM #		MEDI-CAL PENDING ☐ YES ☐ NO REFERRED FOR ELIGIBILITY ☐ 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	MEDI-CAL HMO ☐ YES ☐ NO	CALWORKS ☐ YES ☐ NO	AB3632 ☐ YES ☐ NO	GROW ☐ YES ☐ NO	HEALTHY FAMILIES ☐ YES ☐ NO	HEALTHY FAMILIES CIN # / OTHER FUNDING
7	MEDICARE ☐ YES ☐ NO	MEDI-GAP ☐ YES ☐ NO	CHAMPUS ☐ YES ☐ NO	VET/ADM ☐ YES ☐ NO	PRIVATE INS ☐ YES ☐ NO / HMO ☐ YES ☐ NO	CLAIM #
8	NAME OF CARRIER		GROUP/POLICY/ID #		NAME OF INSURED	
9	CARRIER ADDRESS				ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO	

PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10	NAME OF PAYOR	RELATION TO CLIENT	DOB	MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ SP		PAYOR 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: ________________					PAYOR 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		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	$______________
Net Asset Valuation	$______________			Add monthly asset valuation	$______________
				TOTAL	$______________
				Subtract total expenses	$______________
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	

22	Number Dependent on Adjusted Monthly Income	**ANNUAL LIABILITY**	**ANNUAL CHARGE PERIOD** **FROM** **TO**	Payment Plan $__________________ per month for ____________ months.	
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)				

OTHER

24	PRIOR MH TREATMENT (Only applicable to 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	