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 Self/Payor	$
Checking Accounts	$	Monthly child care payments (necessary for employment)	$	Spouse	$
IRA, CD, Market value of stocks, bonds and mutual funds	$	Monthly dependent support payments	$	Other	$
TOTAL LIQUID ASSETS	$	Monthly medical expense payments	$	TOTAL	$
Less Asset Allowance	$	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$	Add monthly asset valuation	$
Net 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

MH 224A
Revised 10/29/09

CLIENT FACE SHEET

Note: Shaded/Bolded fields must be completed on individuals prior to Triage.
The remainder of the fields must be completed prior to opening an Episode.

***See Client Face Sheet Codes Table for a listing of codes/definitions for the field.**
**** Field is NOT entered into the IS; information gathering only.**

CLIENT DATA

CLIENT I.D.#

Last Name:

First Name: | **Middle Name:**

AKA/Maiden Last Name:

AKA First Name: | **Middle Name:**

SSN: | **Mother's Maiden Name:**

Gender: Male ☐ Female ☐ Other ☐ Unknown ☐ | **DOB:** | **Age:**

English Speaking: Yes ☐ No ☐ | *Primary Lang: | *Preferred Lang: | *Ethnicity:

*If Hispanic, Indicate Origin: | *If American Indian/Alaska Native, Indicate Tribe:

*Education Level : | *Level of Care: | *Conservatorship:

*Handicap: | *Marital Status: | *APR: | Veteran: Yes ☐ No ☐

*Living Arrangement: | *Employment Status: | Date of Death: ____________

****Are there children in the home? Yes ☐ No ☐** | ****Dependent(s) in the home? Yes ☐ No ☐**

****Insurance: Medi-Cal ☐ Medicare ☐ Indigent ☐ Private/Other ☐ ____________ Unknown ☐**

CLIENT ADDRESS

Transient/Homeless: Yes ☐ No ☐ | ***Time Homeless:**

Address:

Second Line:

City: | *State: | Zip: | *County:

Phone (Home): | ****(Cell)** | **(Work)**

Address Memo:

EMERGENCY CONTACTS

DO NOT CONTACT EMERGENCY CONTACTS EXCEPT IN EMERGENCY SITUATIONS WHICH HAVE BEEN CLEARLY DOCUMENTED

Name: | *Contact Type:

Address: | City: | *State: | Zip:

Relationship: | Phone: | Email:

Name: | *Contact Type:

Address: | City: | *State: | Zip:

Relationship: | Phone: | Email:

Complete only if the Client's Child is enrolled in FSP

Child's Name: | Contact Type: **Child Enrolled in FSP**

Address: | City: | State: | Zip:

DMH I.D.# | Phone: | Email:

SFPR and PRIMARY CONTACT

SFPR Name: | Provider Number:

Primary Contact Name: | Provider Number:

BIRTH INFORMATION

Indicate Client Birth Name (If different than the name listed in Client Data)

Last Name: | First Name: | Middle Name:

Birth County: | Birth State: | Birth Country (If born outside US):

Mother's First Name:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Agency: | **Provider #:**

Los Angeles County – Department of Mental Health

CLIENT FACE SHEET