☐ **Registration** ☐ **Update**

Client Name: _____ Client No. / Account No. _____/_____

UMDAP Liability Period From: _____/___/_____ To:_____/___/_____

Number of Dependents: _____ Undetermined Liability: _____

A. Monthly Income		B. Total Assets		C. Monthly Expenses	
1. Self	$	1. Checking	$	1. Court Ordered	$
2. Parent/Spouse	$	2. Savings	$	2. Child Care	$
3. Other	$	3. Other	$	3. Dependant Support	$
4. Total Income	$	4. Total Assets	$	4. Retirement	$
5. Adjusted Income	$	5. Asset Allowance	$	5. Total Medical	$
6. Annual Liability	$	6. Met Assets	$	6. Excess Medical	$
7. Quarterly Payment (County)	$	7. Monthly Assets	$	7. Total Expenses	$
Monthly Payment (Contractor)	$				

Employment Information

Responsible Party (RP) Employer	Spouse's Employer
Name_____	Name_____
Address_____	Address_____
City_____, State_____, Zip Code_____	City_____, State_____, Zip Code_____
Phone_____	Phone_____

Insurance Information

1. Medi-Cal Number_____ Eligibility Period _____
2. Medicare Number_____ Part A Effective Date_____ Part B Effective Date_____
3. Name of Insurance_____ ID Number_____
   Billing Address_____
   Group Number_____ Effective Date_____
   Policy Number_____ Expiration Date_____
   Insured Person's Name_____ Insured Person's Gender: ☐Male or ☐Female
   Insured Person's Social Security Number_____/_____/_____ Relationship to Insured _____

☐Employment Related ☐Assignment of Benefits ☐Release of Information ☐Information Complete

Signatures

I understand that I am obligated to pay the established UMDAP deductible or the actual cost of services received during the UMDAP contract year, whichever is less. I understand that I am obligated to pay for the cost of care up to the UMDAP deductible regardless of when treatment is terminated.

Responsible Party Name (Print)	Interviewer's Signature
Signature of Responsible Party	Date