Payor Financial Form

AGENCY NAME:

Client's Last Name/MH ID # (if known)	**First Name M.I.**	**Alias or other names Used**
Client Date of Birth	**Undocumented?** □ Yes □ No **If no, Social Security Number (Required)**	**26.5 (AB3632)** □ Yes □ No IEP (SELPA) start date_______________

Does Client have Medi-Cal? □ Yes □ No **Share of Cost?** □ Yes □ No **Client's Medi-Cal Number** (BIC Number)**?** ____________

Please attach copy of MEDS Screen

If client has Mcal and no other 3rd party coverage , skip the remaining sections of this form and fax to MIS/Billing Unit – 573-2110

Is Client Potentially Eligible for Medi-Cal Benefits? □ Yes □ No **Client Referred to Medi-Cal?** □ Yes, give date: ________ □ No

Is this a Court-ordered Placement? □ Yes □ No

Does Client have Medicare? □ Yes □ No **If yes, please check all that apply ____Part A ____Part B ____Part D (effective 1/1/06)**

What is the Client's Medicare Number? ________

Responsible Party's Information (Guarantor):

Name ________________ Phone ________________ Relationship to Client ____________ □ Self

Address ________________ City ________________ State __________ Zip Code__________

□ **Refused to provide Financial Information and will be charged full cost of service.**

FINANCIAL ASSESSMENT – Annual UMDAP (Uniform Method of Determining Ability to Pay)

To determine family's UMDAP liability, please list any other family members currently being seen by Mental Health:

____

____

Gross Monthly Income (include all in the Household)

A. Self ………………………………….$ ________
B. Parents/Spouse/Domestic Partner ….$ ________
C. Other ………………………………. $ ________

Number of Persons Dependent on Income ________

Asset Amount (List all liquid assets)

A. Savings……...……………………….$________
B. Checking……..……………………….$________
C. Stocks……………………………….$________

Allowable Expenses

A. Court Ordered Monthly Obligation $________
B. Monthly Child Care Payments (Only if Necessary for Employment) $________
C. Monthly Dependent Support Payments $________
D. Monthly Medical Expense Payments $________
E. Monthly Mandated Deductions for Retirement Plan (Do not include Social Security)…………………………$________
F. Housing Cost (Mortgage/Rent) $________

3rd Party HEALTH INSURANCE INFORMATION

Health Plan or Insurance Company (Not employer)

Name of Company ________________

Street Address ________________

City ________________

State ________________ Zip ________

Insurance Co. phone number________________

Policy Number ________________

Group Number________________

Name of Insured Person________________

Relationship to Client________________

Social Security Number of Insured Person________________
(if other than client)

Does this Client have Healthy Families Insurance? □ Yes □ No
If Yes, complete San Mateo County Mental Health SED form.

Does this Client have Healthy Kids Insurance? □ Yes □ No
Does this Client have HealthWorx Insurance.? □ Yes □ No

CLIENT AUTHORIZATION –This section is not required for Full scope Medi-Cal Clients

I affirm that the statements made herein are true and correct. I understand that I am responsible for paying the UMDAP liability amount or cost of treatment received by myself or by members of my household during each 1-year period. If the cost of service is more than the UMDAP liability amount, I pay the lesser amount. It is my responsibility and I agree to provide verification of income, assets and expenses. If I do not, I will be billed in full for services received. I authorize San Mateo County Mental Health to bill all applicable mental health services to Medicare and/or my insurance plan, including any services provided under 26..5. I authorize payment of healthcare benefits to San Mateo County Mental Health.

________________ ________ ________________
Signature of Client or Authorized Person Date Reason if client is unable to sign

Client Refused to Sign Authorization: ☐ (Please check if applicable) Date__________Reason________________

Name of Interviewer ____________ Phone Number____________ Best Time to Contact__________

FAX COMPLETED COPY TO: MIS/BILLING UNIT (650)-573-2110

San Mateo County Mental Health Services Use Only

ENTERED BY CLIENT ACCOUNT # DATA ENTRY DATE