

BHRS SUD AVATAR
Financial Registration Form

Historical reimbursement methods that BHRS SUD contractors are accustomed to will be changing under the DMC-ODS, to a cost reimbursement method. This method will allow for us to assure client care is charged and claimed correctly on the back end in partnership with BHRS MIS/Billing Unit. The AVATAR Registration/Admission process is outlined below:

SUD Contractors will:

- Continue to engage our clients in financial questions and screenings that will assist in the correct claiming of the services being rendered.
- Continue to get a signed AOB from client

BHRS-MIS will:

- Provide client AVATAR ID to Contractor
- Set-up up all client financials
- Submit service claims to eligible funding sources

BHRS has incorporated the following procedure prior to SUD Contractors opening clients in AVATAR

- At the time of a client being placed on the *waitlist*, **SUD Contractor** will collect the client information on the attached BHRS SUD AVATAR Financial Registration Form and email securely to MIS/Billing Unit at [HS BHRS AOD-Corrections@smcgov.org](mailto:HS_BHRS_AOD-Corrections@smcgov.org) or fax 650-573-2110. Financials are not needed for waitlist clients.
 - **MIS** will research the client in AVATAR and email the provider the clients AVATAR ID or the clearance to register and admit the client in AVATAR. (within 24 business hours)
- At the time of a client *admission*, **SUD Contractor** will collect the required information on the attached BHRS SUD AVATAR Financial Registration Form and email securely to MIS/Billing Unit at [HS BHRS AOD-Corrections@smcgov.org](mailto:HS_BHRS_AOD-Corrections@smcgov.org) or fax 650-573-2110. All BHRS clients including DUI/DEJ must complete the attached.
 - **MIS** will research the client in AVATAR and email the provider the clients AVATAR ID or the clearance to register and admit the client in AVATAR. (within 24 business hours)
- After receiving the AVATAR ID or the clearance to register the client, **SUD Contractor** will continue in the AVATAR admission process.
- When **SUD Contractor** is made aware of financial source changes, the SUD Contractor shall send an updated BHRS SUD AVATAR Financial Registration Form to MIS.
- Once **MIS** is provided with the update, MIS will modify the AVATAR financials for that client.

**BHRS SUD AVATAR
Financial Registration Form**

FORM FACTS-

1. All Clients with OHC are not eligible for BHRS funded services;
2. All fields are required to completed or mark with N/A;
3. The AVATAR Program Code is assigned AVATAR for each facility;
4. Form is to be completed on all BHRS clients including DUI/DEJ clients;
5. Financials are not needed for DUI/DEJ program participants;
6. The form is not for private pay clients;
7. The address used under Responsible Party's Information should be the address the client wants to use or the last Medi-Cal Address.

Ranking of funding sources-

The following is the Ranking of Funding Priorities for San Mateo County Residents Seeking SUD Treatment Services

CLIENTS WITH THE FOLLOWING RESOURCES	FUNDING OF FIRST RESORT →	FUNDING OF SECOND RESORT →	FUNDING OF THIRD RESORT →
Uninsured Residents	SAPT / SAPT Peri	County	
Residents with Medi-Cal ONLY	DMC	SAPT / SAPT Peri	County
Residents with ACE	SAPT / SAPT Peri	County	
Residents with Medicare ONLY	SAPT / SAPT Peri	County	
Residents with Medi / Medi	Medicare	DMC (if OHC will not pay / cover)	SAPT
Residents with Medi-cal and OHC	OHC	DMC (if OHC will not pay / cover)	
Residents with OHC	OHC		
<i>*residents includes adults and adolescents</i>			
Examples			
Uninsured Adolescents	SAPT	County (including Measure A)	
Adolescents with OHC	OHC	SAPT	County (including Measure A)
Adolescents with Medi-Cal	DMC	County (including Measure A)	
CJ client w/ no coverage	CJ funding*	SAPT / SAPT Peri	County
CJ client w/ OHC	OHC	CJ Funds	
CJ client with Medi-Cal	DMC	CJ Funds	
CalWorks client	Calworks	DMC	
CJ Client w/ CalWorks	Calworks	DMC	CJ Funding
* CJ= AB109, Unified Reentry, Drug Court, Pathways, Probation referral, Modifiable, Court Referred OHC= Other Health Care SAPT- Substance Abuse Pv & Tx Block Grant DMC= Drug Medi-Cal DMC is always funding as last resort SAPT is always funding as last resort CalWorks is always funding as last resort			

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SUD/DMC TX DUI DEJ

<input type="checkbox"/> Initial Request <input type="checkbox"/> Update	Date: _____	Program: _____
Client ID: <i>(for MIS use)</i>	AVATAR Program Code: _____	Program Contact & Phone No: _____
Client SSN: _____	Client Date of Birth: _____	Admission Date: _____
Last Name: _____		First Name: _____ M.I. _____
Alias or other names used: _____		Undocumented: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to state
Does Client have Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Client's Medi-Cal Number (CIN Number)? _____		
Is client potentially eligible for Medi-Cal benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Client referred to Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Client have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please check all that apply ___Part A ___Part B ___Part D		
What is the Client's Medicare Number (HIC Number)? _____		
Signed Assignment of Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Please attach copy of Medicare card		
Eligible Treatment Funding Sources: _____DMC _____CalWorks _____SAPT _____SAPT Perinatal _____County _____Criminal Justice _____Measure A (youth)		
Eligible <input type="checkbox"/> Room & Board <input type="checkbox"/> Recovery Residence(RR) Funding Sources: RR Program No: _____ <input type="checkbox"/> CalWorks <input type="checkbox"/> SAPT <input type="checkbox"/> SAPT Perinatal <input type="checkbox"/> County <input type="checkbox"/> Criminal Justice		
Comments: _____		
Responsible Party's Information (Guarantor):		
Name: _____		Phone: _____
Relationship to Client: _____		<input type="checkbox"/> Self
Address: _____		City: _____
State: _____		Zip Code: _____
3rd Party Health Insurance Information (Not employer) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Company Name: _____		Policy Number: _____
Street Address: _____		Group Number: _____
City: _____		Name of Insured Person: _____
State: _____ Zip: _____		_____
Insurance Co. phone number: _____		Relationship to Client: _____
Please attach copy of insurance card (front and back) _____		
Signed Assignment of Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		SSN of Insured Person (if other than client): _____

Email to MIS/Billing Unit [HS BHRS AOD-Corrections@smcgov.org](mailto:HS_BHRS_AOD-Corrections@smcgov.org) or 650-573-2110