FINANCIAL INFORMATION FORM

①**Person receiving services:** Last Name	First Name	M.I.	**GRAYED OUT AREAS FOR PROVIDER USE ONLY:**
Maiden or Other Name (if any)			Eligibility Verified? ◯ Yes ◯ No
Birthdate	SSN		Avatar ID#:
Daytime Phone Number	Secondary Phone Number		Email Address

RECORD OF FINANCIAL DATA

②Employer Business Name			☐ Full Time ☐ Part Time
Employer Address: Number Street	City	State …	Zip Code
③Does the person receiving services have Medi-Cal? ◯ Yes ◯ No	Medi-Cal ID:	Eligibility Verified? ◯ Yes ◯ No	
④Does the person receiving services have Medicare? ◯ Yes ◯ No	Medicare HIC:	Eligibility Verified? ◯ Yes ◯ No	
Do services require an ABN (Advanced Beneficiary Notice)? ◯ Yes ◯ No		Is completed ABN signed, dated and on file? ◯ Yes ◯ No	

⑤Does the person receiving services have other health insurance? (HMO, PPO, EPO, Indemnity, ERISA, etc.) ◯ Yes ◯ No If yes, **ATTACH COPY OF CARDS**	Health plan or insurance carrier name	Policy/Group Number	Policy Verified? ◯ Yes ◯ No
Primary Subscriber's Name Date of Birth	Relationship to person receiving services: ☐ Self ☐ Other:	Employee ID	
⑥Does the person receiving services have a secondary other health insurance? (HMO, PPO, EPO, Indemnity, ERISA, etc.) ◯ Yes ◯ No If yes, **ATTACH COPY OF CARDS**	Health plan or insurance carrier name	Policy/Group Number	Policy Verified? ◯ Yes ◯ No
Primary Subscriber's Name Date of Birth	Relationship to person receiving services: ☐ Self ☐ Other:	Employee ID	

AGREEMENT TO PAY (Check Only ONE Box)

⑦ ◯ I ***(the person receiving services)*** have full-scope Medi-Cal

- I agree that if I no longer qualify for or do not have Medi-Cal or other health insurance, I will be reevaluated by my provider to determine eligibility and potential financial obligation.

⑧ ◯ I will pay the monthly share-of-cost/copay responsibility for services provided	UMDAP year start date:
⑨ ◯ I will pay an annual UMDAP responsibility for services provided as agreed upon with my provider	
⑩ ◯ I refuse to provide financial information and I have been notified that I will be charged in full for services received	Annual UMDAP liability:

- I agree to provide information to Sacramento County about other health insurance that I may have.
- I agree to tell my service provider within 30 days if there are any changes in my financial situation. I understand that any of these changes may also change the amount I need to pay each year.
- By signing this form I agree that the information provided is complete and truthful. If not, it may result in my having to pay for the full cost of services received.

I hereby authorize insurance benefits for services received at a Sacramento County mental health facility or authorized contracted provider to directly to the County of Sacramento.

⑪ Financially Responsible Party or Legal Representative: Name	Relationship	Daytime Phone Number
Address: Number Street City State … Zip Code		Secondary Phone Number

Signature of responsible party	Date	Signature of Provider Representative	Date

INSTRUCTIONS: Complete the entire form as it pertains to the person receiving behavioral health services.

DEMOGRAPHICS SECTION

① **Person receiving services:** Enter the name, birthdate, Social Security Number, phone numbers and email address of the person to receive behavioral health services

RECORD OF FINANCIAL DATA SECTION

② **Employer:** Enter the employer name and address. Indicate in the appropriate box whether the position is full- or part-time.

③ **Medi-Cal:** Indicate whether the person receiving services is enrolled in Medi-Cal; enter the Medi-Cal ID number as shown on their Medi-Cal card.

④ **Medicare:** Indicate whether the person receiving services is enrolled in Medicare; enter the Medicare ID number as shown on their Medicare card.

⑤ **Other Health Insurance:** Indicate whether the person receiving services has a health insurance policy through an employer or purchased privately such as Kaiser, Dignity Health, etc. If so, enter:

- The health plan or insurance carrier name
- The policy and group number
- The primary subscriber's name and birth date. If you have insurance through your parent(s), spouse, or registered domestic partner, the parent/spouse/domestic partner would be the primary subscriber.
- The relationship to the person receiving services. If the person receiving services is the primary subscriber, check the box indicating 'Self'.

⑥ **Secondary Other Health Insurance:** Indicate whether the person receiving services has a *second* health insurance policy through an employer or purchased privately such as Kaiser, Dignity Health, etc. If so, enter:

- The health plan or insurance carrier name
- The policy and group number
- The primary subscriber's name and birth date. If you have insurance through your parent(s), spouse, or registered domestic partner, the parent/spouse/domestic partner would be the primary subscriber.
- The relationship to the person receiving services. If the person receiving services is the primary subscriber, check the box indicating 'Self'

AGREEMENT TO PAY SECTION – only check ONE box in this section.

⑦ Check this box if the person receiving services has full-scope Medi-Cal (Medi-Cal with no share-of-cost).

⑧ Check this box if you have Medi-Cal with a share-of-cost or if you have Medicare or other health insurance with a monthly copay requirement. By checking this box, you agree to pay this cost.

⑨ Check this box if you've made arrangements to pay an UMDAP amount.

- UMDAP Year Start Date is the first day of the month that the UMDAP amount was created
  - Example: if services began on July 25, 20XX; the year start date would be July 1st, 20XX
- Annual UMDAP liability is the dollar amount a customer is responsible to pay for one year of services per their UMDAP agreement

⑩ Check this box if you choose not to provide financial information. In doing so, you agree to be responsible to pay for any services provided to you through the Mental Health Plan.

⑪ Enter the name of the person who is financially or legally responsible for the person receiving services. If you are both the person receiving services and the financially responsible party, write your name and enter 'self' in the Relationship box. Enter the address and phone number(s) for the financially responsible party/legal representative. Have the financially responsible person sign and date on the appropriate lines. The 'Signature of witness' is reserved for the provider representative.

DEFINITIONS:

ABN: A notice alerting those who have Medicare that services provided may not be covered by Medicare

Copay: An individual's payment responsibility amount for a covered service, paid when the individual receives service

EPO: Exclusive Provider Organization

ERISA: Employee Retirement Income Security Act

Full-scope Medi-Cal: Medi-Cal coverage with no share-of-cost, where all covered services are free to the recipient

HMO: Health Maintenance Organization

Indemnity insurance: An insurance policy that aims to protect business owners and employees when they are found to be at fault for a specific event such as a misjudgment

PPO: Preferred Provider Organization

Share of Cost: the monthly dollar amount a Medi-Cal recipient pays before Medi-Cal aid is applied

UMDAP: Uniform Method of Determining Ability to Pay