CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

# Financial Information (Annual Liability/ UMDAP)

NAME / MRN

## FAMILY ATP

**Income Type:** ☐Self ☐Parent / Spouse ☐Other

**Gross Monthly Income** (Except foster care children): $ _____

**Number of Dependents** _____

**Asset Allowance** (Checking, savings, stocks, bonds, etc.): ☐Checking ☐Savings ☐Other $ _____

Court ordered obligations paid monthly $ _____

Monthly (necessary for employment) $ _____

Monthly dependent support payments $ _____

Monthly medical expense payments (in excess of 2% of gross income) $ _____

## PAYOR

**Insurance:** (check all that apply)

☐ None ☐Medi-Cal ☐Medicare ☐CCHP Insured Last Name: _____

Insurance ID (CIN, SSN, CCHP ID, Medi-Care #): _____ Client Relation to Insured: _____

☐ Private Insurance Name: _____

☐ Group #: _____ Insurance ID: _____

## INSURED (if other than Self)

Subscriber Name: _____ Subscriber SS#: _____

Subscriber Birth Date: _____ Phone# _____

| Initial | |
|---|---|
| | I hereby assign any benefits payable by the above to Contra Costa County Health Services. This amount is not to exceed the regular charges for this period of services. |
| | I authorize the County to bill any and all identified commercial insurance coverage on my behalf. |

☐ Client states financial hardship: requests fee waiver

_____ _____

Responsible Party/Legal Guardian Signature Date

***Child and Family Services is the responsible party for children in Foster Care. The social worker must sign in the Responsible Party section as the representative.***

_____ _____

Staff Signature Date

## Office Use Only

Liability/UMDAP Liability Period: _____ Effective Date _____

Expiration Date: _____ Guarantor ID #: _____ UMDAP Liability: _____

Reviewed By: _____ Date: _____ Data Entry Clerk Initials: _____

DRAFT