San Diego Behavioral Health Services
California Client Financial Review Maintenance

Client Name:	**Case Number:**	**SSN:**	**DOB:**
Review Date:		**Status:** ☐ New ☐ Update	Annual

Main [1]

Financial Type: ☐ Individual ☐ Family (Complete "Family Members" section below): Program: ☒ Mental Health

Family Members:

Name:	Case#:

Bill To:

Name:	Relationship to Client:	
Address:		
City:	State:	Zip Code:
Phone:		

Assignment of Benefits Signed?
☐ Yes If YES, Note date signed and location where AOB is on file in the "Comments" Section on page 2.
☐ No If NO, Insurance will not be billed.

Financial Info Provided/Verified
☐ Yes ☐ No
If NO, Select Reason from Table:
☐ N – Not Applicable
☐ P – Documentation Pending
☐ R – Documentation not Provided/Refused
☐ U – Unemployed

Suppress printing statements?
☐ Yes ☐ No
If YES, Select Reason from Table:
☐ CR – Client Request
☐ H – Homeless
☐ N – No Permanent Mailing Address

Financial [2]

A. Gross Family Income

Number dependent(s) on income: _____

	Monthly	Annual
1. Responsible Person:		
2. Spouse:		
3. Other (Name of Source):		
4. **Total Gross Income:**		

Client Name:	**Case Number:**	**SSN:**

B. Liquid Assets		C. Allowable Expenses	Monthly	Annual
1. Savings Accounts		1. Court Ordered Obligations		
2. Checking Accounts		2. Child Care (necessary for employment)		
3. Other		3. Dependent Support		
4. Total Liquid Assets		4. Medical Expenses		
5. Asset Allowance		5. Medical Expenses in excess of 3% Gross Income		
6. Net Assets		6. Mandated Deductions for Retirement Plans		
7. Monthly Liquid Assets		**7. Total Allowable Expenses**		

UMDAP Calculations			**Box**
Total Monthly Gross Income (From pg. 1)	$		A4
Subtract Total Allowable Expenses	$		C7 (-)
Subtotal	$		(=)
Add Adjusted Monthly Liquid Assets	$		B7 (+)
D. Adjusted Gross Income	$		D (=)

Max Annual Liability: $	For an Override, follow Therapeutic Adjustment P&P #01-08-205 and/or Financial Eligibility and Billing Manual, page 24.
For Liability Period:	Through:

Payment Plan [3]

Payment Plan: ☐ Yes	
Agreed upon Payment Amount: $	Per: ☐ Month ☐ Visit

Comments [4]

Name of Insurance AOB is signed for:

Date AOB Signed: **AOB on file at (Unit/Subunit):**

Signatures [5]

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)_____

Signature of Responsible Party_____ Date_____

Interviewer's Signature_____ CCBH SYSTEM ID#_____

California Client Financial Review Maintenance

Main (1)

Client Name	Last Name, First
Case Number	Client Number
SSN	Social Security Number
DOB	Date of Birth
Status	New, update, or annual UMDAP
Date	Date information was collected, maybe different from UMDAP date.
Financial Type Individual vs. Family Notes: The UMDAP will cover the whole family for a year of mental health services as long as the family members are U.S. Citizens or Registered Legal Aliens. Undocumented clients are only eligible to receive emergency services at EPU and ESU. The UMDAP will cover the whole family for a year of emergency mental health services only.	Individual meaning only one person receiving Mental Health Services. Family meaning more than one person receiving Mental Health Services. (If you mark Individual and find out later that they have someone in their family receiving services you can link the two acct. this is an CCBH SYSTEM feature.)
Program	Always Mental health
Family Members	All family members in the mental health system and write their case number beside their name. (If known)
Bill to	The responsible party that would receive the bill. This includes client.
Assignment of Benefits signed	Mark if you have an AOB on file with signature. Also, AOB is NOT needed for Med-Cal clients.
Financial Information Provided	If the financial information was verified, check this box.
Reason Not Verified	If the financial information box is not checked, please indicate reason: N-N/A P-Documentation Pending R-Doc not Provided/Refused U-Unemployed
Suppress Printing Statements	Check this box if statements are not to be printed/sent to client.
Suppress Reason Note: Client can request suppress printing statement does NOT mean client will not be responsible for UMDAP.	If “Suppress Printing Statements” box is checked, please indicate reason: CR- Client Request H-Homeless N-No Perm Mail Address MC- Minor Consent

FINANCIAL (2) TAB

Number of Dependents	The number of dependents must include parent(s) and all children under the age 18 which the parent is financially supporting over 50%.
Gross Family Income (Box A) **Notes:** NOTES: Gross Income means total family income before allowances for taxes and other deductions. In the case of self-employed persons, it is total income after business expenses have been deducted. If client claims no income, ask how they are supporting themselves.	(Line 1) Responsible person, if self-enter client's monthly or annual gross income. If client is a child enter parents/legal guardian's monthly or annual gross income.
	(Line 2) Spouse's income, if any. Leave blank if none.
	(Line 3) Other income. This can include income from SSA, CalWIN, Child support, Spousal support, Dividends, Interest & Rental income.
	(Line 4) Total Gross income. Add lines 1, 2 and 3 to get your gross income.
Liquid Assets (Box B) Note: The clients' income maybe deposited in the acct. So always use the average balance when using checking or saving accounts to avoid counting the clients income twice.	(Line 1) Savings Account. Average Savings balance, if none enter zero.
	(Line 2) Checking Account. Average Checking balance, if none enter zero.
	(Line 3) Other Assets. Any Assets personal or real property which can readily be converted into cash and may increase ability to pay. This can include stocks, bonds and mutual funds
	(Line 4) Total Liquid Assets. Add lines 1, 2 and 3 to get your total.
	(Line 5) Asset Allowance. Refer to 1989 Asset Schedule. It is based on family size. Enter the Asset Allowance amount on line 5.
	o If the amount on line 5 (Asset Allowance) is **greater than** line 4 (Total Liquid Assets) put a zero on line 6 (Net Assets) and a zero on line 7 (Liquid Monthly Assets). This means that their assets are not going to affect their monthly gross income. (See Example 1) o If the amount on line 5 (Asset Allowance) is **less than** line 4 (Total Liquid Assets) subtract line 5 from line 4 to get the amount that will go into line 6 (Net Assets). Now divide the Net Asset amount by 12 to get the amount that will go into line 7 (Monthly Liquid Assets). You will need to round off the amount on line 7 to the nearest dollar. Now add the amount from Box B – line 7 to Box A – line 3 as other income. This will give you your new total gross income. (See Example 2).