

ATTACHMENT D

Department of Developmental Services

State of California - Health and Welfare Agency

CLIENT INFORMATION

1. Name	Date of Birth	File Number
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RESPONSIBLE PARTY INFORMATION

2. Name	Relationship to Client	Date of Birth	Marital Status
3. Address			Telephone Number
4. Veteran			Social Security Number
5. Employer	Position	If not employed, date last worked	
6. Employer's Address			Telephone Number
7. Spouse	Address		
8. Spouse's Employer	Position	If not employed, date last worked	
9. Spouse's Employer's Address			Telephone Number
10. Nearest Relative	Telephone/Address		

THIRD PARTY INFORMATION

11. Insurance Company	Address
12. Policy/Group/ID Number	Assignment/Release of Information obtained
13. V.A. Claim Number	Medicare Claim Number
14. Medi-Cal Claim Number	Date referred for Eligibility Determination

PRIOR SHORT/DOYLE TREATMENT

15. Prior Short/Doyle Treatment:	From:	To:
Where:	Monthly Payment	
16. Present Short/Doyle Balance		

PAYOR FINANCIAL INFORMATION

*Confidential
Client Information
See W&I Code, Section 5328*

FINANCIAL LIABILITY

Schedule of Asset Allowances

17. Gross monthly family income: Responsible person _____
 Spouse _____
 Other _____

18. TOTAL _____

19. Number dependent on income _____

Persons			
1	\$1500	6	\$2600
2	\$2250	7	\$2700
3	\$2300	8	\$2800
4	\$2400	9	\$2900
5	\$2500	10 or more	\$3000

ASSET DETERMINATION

20. List all liquid assets (savings, bank balances, market value of stocks, bonds and mutual savings):

Source _____	Amount: \$ _____
_____	\$ _____
_____	\$ _____

21. Total of liquid assets \$ _____

22. Insert amount from schedule of Asset Allowances \$ _____

23. Total net liquid assets (Deduct line 22 from line 21) \$ _____

24. Divide line 23 by 12 months \$ _____

25. Add lines 18 and 24 \$ _____

ALLOWABLE EXPENSES

26. Court ordered obligations paid monthly \$ _____

27. Monthly child care (necessary for employment) \$ _____

28. Monthly dependent support payments \$ _____

29. Monthly medical expense payments in excess of 8% of gross income \$ _____

30. Monthly mandated deductions from gross income for retirement plans (not Social Security - Allowance made in payment schedule) \$ _____

31. Total allowable expenses (add lines 26 through 30) \$ _____

32. Deduct line 31 from line 25 (adjusted gross income) \$ _____

33. Use line 19 and line 32 to determine the annual liability from Fee Schedule \$ _____

34. Agreed upon payment plan to satisfy the above liability \$ _____

35. Annual liability and service period: From _____ To _____

36. Provider of Financial Information (if other than patient or responsible person)

Name _____ Address _____

37. Adjusted by _____ Reason _____

38. Approved by _____ Date _____

39. I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 34.

▶ _____ Date _____
 Signature of Patient or Responsible Person

40. An explanation of the UMDAP liability was provided.

▶ _____ Date _____
 Signature: Interviewer