Alpine County Behavioral Health Services
Demographic Form

TODAY'S DATE: _____ CLIENT #: _____

1ST ACCESS DATE: _____ DATE OF 1ST APPOINTMENT: _____

INDEX CARD - ALL CAPS

Client #:

Sort Name:

Last, First Middle

Legal Name:

***Last Name:**	***First Name:**
Middle:	Suffix:
***DOB:**	**Soc Sec #:**

CLIENT IDENTIFYING INFORMATION - use sentence case

Effective Date:	**Admission Status:** ❍ **Admit**

***(6)Referral Source: Circle One** **Referral Phone:**

(1) Self
(2) Family
(3) Friends
(4) Employer
(5) Community Referral
(7) Health Care Provider
(13) Jail
(19) Private MH Practice
(26) Criminal Justice /non-SACPA
(27) Drug Abuse Program
(28) Alcohol Abuse Program
(29) School / College
(34) CALWORKS
(39) SACPA/Prop 36/OTP/Probation or Parole
(40) Post Release (AB109)
(41) CPS / Dependency Court
(43) DUI / DWI
(99) Unknown / Not Reported

***Birth Name (if different from above):**

Last Name:	First Name:
Middle:	Suffix:
***Physical Address:**	Apt. #:
***City/State/Zip:**	***(21)County:**
***Home Phone:**	Work Phone: Ext.
Cell Phone:	
***Mailing Address:**	Apt. #:
***City/State/Zip:**	
***Driver's License:** ❍**Yes** ❍**No**	**DL No.:** **State:**
***Social Security #:** (If SSN not entered above)	**(8)Reason SSN Not Provided:** (*If SSN blank)
***(7)Gender: Circle One** (F) Female (M) Male (O) Other	***Is DOB:** ❍ **Actual?** ❍ **Estimated?**

Born in US: ❍ Yes ❍ No

Born in California: (*If born in US, else disabled and set to No) ❍ Yes ❍ No

Place of Birth:	***(21)County:**	***(22)State:**	**(23)Country:**

***Mother's First Name**

***(9)Marital Status:** Not used at this time

***(10)Ethnicity: Circle One**
(1) Not Hispanic (2) Mexican / Mexican American (3) Cuban (4) Puerto Rican (5) Other Hispanic / Latino

Client Name: _____ Client #: _____

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***(11)Race: Circle One**

(A) Asian – Other	(G) Guamanian	(M) Mien	(S) Samoan
(B) Black / African American	(H) Hawaiian Native	(N) Native American	(V) Vietnamese
(C) Cambodian	(I) Asian Indian	(O)) non-White – Other	(W) White
(D) Chinese	(J) Japanese	(P) Pacific Islander – Other	(U) Unknown / Not Reported
(E) Eskimo / Alaskan Native	(K) Korean	(Q) Hmong	
(F) Filipino	(L) Laotian	(R) Multiple	

***(12)Primary Language: Circle One**

(1) American Sign Language	(C) Chinese Dialect	(K) Korean	(S) Spanish
(2) Other Sign Language	(D) Cambodian	(L) Lao	(T) Turkish
(3) Samoan	(E) English	(M) Mien	(V) Vietnamese
(4) Other Chinese	(F) French	(N) Thai	(W) Filipino Dialect
(5) Tagalog	(G) Cantonese	(O) Other non-English	(X) Hmong
(6) Mandarin	(H) Hebrew	(P) Polish	(Y) Ilocano
(A) Armenian	(I) Italian	(Q)) Farsai	(Z) Portuguese
(B) Arabic	(J) Japanese	(R) Russian	(U) Unknown / Not Reported

***(13)Communication Method: Circle One**

(C) Communication Device	(T) Translator – Spanish	(V) Verbal
(S) Sign Language	(X) Translator – Other	

***(12)Language Preferred (Individual): Indicate Code (from prim lang above) _____**

****(12)Language Preferred (Caretaker): Indicate Code (from prim lang above) _____**

***Interpreter Needed?: ❍ Yes ❍ No**

***(14)Employment Status: Circle One**

(1) Comp Job 35+ hours/week	(7) Rehab < 20 hours/week	(F) Not in labor Force
(2) Comp Job <20 hours/week	(8) Full Time Student	(H) Resident / Inmate
(3) Comp Job 20–35 hours/week	(B) Volunteer	(K) Other
(4) Homemaker	(C) Unemployed, seeking work	(U) Unknown / Not Reported
(5) Rehab 35+ hours/week	(D) Unemployed, not seeking work	
(6) Rehab 20–35 hours/week	(E) Retired	

***(15)Living Arrangement: Circle One**

(1) Foster Home – Child	(10) Comm Treatment Facility	(19) SNF/ICF/IMD for psych
(2) SRO – hotel, motel, rooming house	(11) State Hospital	(21) Correctional Facility – Adult
(3) Gp Quarters – dorm, brks, mig camp	(12) VA Hospital	(22) Correctional Facility – Minor
(4) Group Home – LV1 1–12 Child	(13) SNF/ICF/NH Physical Health	(25) Other
(5) House or Apartment	(14) MH Rehab Center	(26) SA Residential/Rehab
(6) House or Apt w/ Support	(15) PHF/Inpatient Psychiatric	(27) Board & Care
(7) House or Apt w/ Supervision	(16) Sober Living	(28) Residential Treatment Center – LV1 13–14
(8) Supported Housing	(17) Specialty Transitional	(99) Unknown / Not Reported
(9) Residential Treatment Center for the elderly	(18) Homeless	

***Number of Children under age 18 the client cares for/responsible for 50% or more ofthe time?:**

***Number of Dependents age 18 or older the client cares for/responsible for 50% or more of the time?:**

***(16)Education (highest grade completed):** Special Education: ❍Yes ❍No

District of Residence: Not used at this time

***(18)Disability: Circle One**

(C) Declined to State	(H) Hearing	(S) Speech
(D) Developmentally Disabled	(M) Mobility	(V) Vision
(E) Mental Health	(O) Other Disability (not AOD)	(N) None

***Veteran:** ❍ Yes ❍ No Branch:

Client Name: _____ Client #: _____

Alpine County Behavioral Health Services
Demographic Form

Alias(es)/Maiden Name			
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:

EMERGENCY NOTIFICATION INFORMATION		
	***Name:**	***(17)Relationship:** See page 4
	Address:	Home Phone:
	City/State/Zip:	Work Phone:
	Employment Place:	
LEGAL INFORMATION		
	***(24)Legal Consent:** See page 4	
	***Responsible Person:**	***(17)Relationship:** See page 4
	*Address:	Phone:
	*City/State/Zip:	
	Employment Phone:	Employment Place:
	Responsible Party SSN:	
MEDICAL INFORMATION		
	*Personal Physician:	Phone: FAX:
	Address:	
	City/State/Zip:	
	Pharmacy:	Phone: FAX:
	Hospital Preference:	
ADVANCE DIRECTIVE INFORMATION		
	Advance Directive Given? ❍Yes ❍No	
CLIENT CONTACT INFORMATION		
	May we leave message at home? ❍ Yes ❍ No	
	May we leave message at work? ❍ Yes ❍ No	
	May we leave message via emergency contact? ❍ Yes ❍ No	
	May we leave message on your cell? ❍ Yes ❍ No	
	May we contact you by mail? ❍ Yes ❍ No	
	NPP Given? ❍Yes ❍No Form Signed Date:	
	If we cannot contact you by mail, then what is an alternative address or method of contact to send you clinical information such as letters and billing information?	

Client Name: _____ Client #: _____

Alpine County Behavioral Health Services
Client Financial Review Form

BILLING OF SERVICES AND ASSIGNMENT OF BENEFITS

You have or will be receiving services provided by Alpine County Behavioral Health Services. We are a county agency and rely upon Federal, State, County, client and other funding sources to pay for the services we offer. Depending on your financial resources and available benefits, you may be responsible to pay for some or all of the fees associated with the services provided to you. Because of this, every consumer who receives services is asked to complete a Financial Review Form. Based on the information you provide to us, we will determine an amount that would be your maximum annual liability for payment for services. This determination will consider your Family size, Monthly Income, Total Assets and Allowable Deductions and will follow the California Department of Mental Health's Uniform Method of Determining Ability To Pay (UMDAP). Verification of the information will be required, as needed. The Annual Liability can either be paid in full or on a monthly basis. The method of payment will be determined when the Annual Liability amount is set. The Annual Liability will be updated every twelve months. If more than one person in the family receives services, all will be covered by one Annual Liability amount. As long as your financial situation remains the same, you will never be obligated for more than your Annual Liability, even if the cost of your care may be higher.

If you are on **Medi-Cal without a Share of Cost**, you will not be charged the Annual Liability. However, if you go off of **Medi-Cal**, Behavioral Health will bill you in accord with your Annual Liability. If you are on **Medi-Cal with a Share of Cost,** you will be responsible for paying the Share of Cost up to the Annual Liability amount.
If you have **Medicare and/or Private Insurance**, these third parties will be billed for the services provided. If the full amount is not paid by the third party and you do not also have Medi-Cal, you will be responsible for the remainder of the cost up to your Annual Liability amount. **Medicare covers only certain services provided by Medicare certified clinicians and private insurance often covers only a limited number of services.** If your Private insurance is a supplement to Medicare, it will follow the Medicare rules. Consequently, even if you have third party coverage, you could still be liable for payment up to the Annual Liability amount.
If you have **Medicare and Medi-Cal:**

a) without a Share of Cost, and your services are not fully covered by Medicare, the services will then be billed to Medi-Cal. You will not be responsible for the cost.

b) with a Share of Cost, and your services are not fully covered by Medicare, you are not considered to be on Medi-Cal until the Share of Cost is met and we must collect your Share of Cost up to the Annual Liability amount before billing Medi-Cal.

If you are covered by any insurance/benefit plan, you must give us the right to bill and receive payment for services provided to you by signing the authorization and acknowledgement below.

AUTHORIZATION AND ACKNOWLEDGEMENT

I understand and accept that I am financially responsible for all services provided by Alpine County Behavioral Health Services up to the Annual Liability amount. I authorize Alpine County Behavioral Health Services to release to my insurance company or other third party payor any personal or medical information necessary to determine benefits and/or for the processing of claims for payment. I also authorize payment of medical benefits by any third party insurer/payor to Alpine County Behavioral Health Services for services rendered. I permit a copy of this authorization to be used in place of the original.
I agree to provide all necessary insurance/benefit information to Alpine County Behavioral Health Services for the processing of claims for services rendered to me.
I acknowledge that I have read, understood and agree to the billing policies above.

Client Signature_____ **Date:**_____

Confidential Patient Information - See California Welfare and Institutions Code Section 5358

ALPINE COUNTY BEHAVIORAL HEALTH SERVICES	NAME_____
Client Cost/How Billed	CLIENT NO:_____

Alpine County Behavioral Health Services
Client Financial Review Form

Client Name:			Client Number:		
Financial					
*Number dependents on income:					
Gross Family Income				**Monthly**	**Annual**
			Responsible Party (Self)		
			Spouse		
Misc. Income:	Family			[redacted]	
	Disability				
	Social Security			[redacted]	
	Unemployment				
	Public Assistance				
	Additional Source				
	SubTotal (enter in "Other" field below)			[redacted]	
			Other		
			Gross Income		

Liquid Assets

Checking Accounts		[redacted]
Savings Accounts		
Other		
Gross Liquid Assets		
Asset Allowance		[redacted]

Allowable Expenses	**Monthly**	**Annual**
Court Ordered Obligations		
Child Care (necessary for employment)		
Dependent Support		
Medical Expenses		
Medical Expenses in excess of 3% Gross Income		
Mandated Deductions for Retirement Plans		
Total Allowable Expenses		

Signature of Patient or Responsible Person

Date