



**NEVADA COUNTY – HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH DEPARTMENT
Client Financial Review Form**

Client Name:	Client Number:
	Soc Sec #:

Main (1) tab	
*Review Date: Use Actual	
*Reviewed By:	
*Financial Type: <input type="radio"/> Individual <input type="radio"/> Family	*Program: <input type="radio"/> Mental Health <input type="radio"/> Substance Abuse <input type="radio"/> Both
Family Members in Treatment	
Name: (*for Family Financial Type)	Client#:
Name:	Client#:
Bill To: (Responsible Person defaulted from Registration Form)	
<input type="checkbox"/> Assignment of Benefits Signed? (Check box if "Yes")	
<input type="checkbox"/> Financial Info Provided/Verified (Check box if "Yes")	
Reason for Unverified Income: <input type="radio"/> N – N/A <input type="radio"/> U – Unemployed <input type="radio"/> P – Documentation Pending <input type="radio"/> R – Doc Not Provided/Refused	
<input type="checkbox"/> Suppress printing statements	
(27) Suppress Reason: (*If suppressing statements)	
<input type="radio"/> A – Administrative <input type="radio"/> N – No Permanent Mailing Address <input type="radio"/> H – Homeless <input type="radio"/> CR – Client Request <input type="radio"/> MR – Management Request <input type="radio"/> T – Therapeutic	

Financial (2) tab			
*Number dependents on income:			
Gross Family Income		Monthly	Annual
Responsible Party (Self)			
Spouse			
Misc. Income:	Family		
	Disability		
	Social Security		
	Unemployment		
	Public Assistance		
	Additional Source		
SubTotal (enter in "Other" field below)			
Other			
Gross Income			



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Liquid Assets (Container disabled if Program = Substance Abuse)

Checking Accounts		
Savings Accounts		
Other		
Gross Liquid Assets		
Asset Allowance		

Allowable Expenses (Container disabled if Program = Substance Abuse)

	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		

	Monthly	Annual
Adjusted Gross Income		

Mental Health UMDAP (Container disabled if Program = Substance Abuse)

Max Annual Liability	\$	
For Period:		Thru:

Payment Plan (3) tab

<input type="checkbox"/> Payment Plan	
Agreed upon Payment Amount (*If Payment Plan) \$	Per (*If Payment Plan) <input type="radio"/> Month <input type="radio"/> Visit

Comments (4) tab

Comments:

Signature of Client or Responsible Person _____

Date _____



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BILLING OF SERVICES AND ASSIGNMENT OF BENEFITS

You have or will be receiving services provided by Nevada County Behavioral Health (“NCBH”). 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 Nevada County Behavioral Health up to the Annual Liability amount. I authorize NCBH 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 NCBH 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 Nevada County Behavioral Health 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

NEVADA COUNTY BEHAVIORAL HEALTH DEPARTMENT	NAME _____
Client Cost/How Billed	CLIENT NO: _____