County of San Luis Obispo Behavioral Health
UMDAP Financial Assessment

Client Name _____ **Client ID** _____

Responsible Party Information

Client is responsible party ☐ Yes ☐ No **Medi-Cal Eligible** ☐ Yes ☐ No

Name _____

Address Street Address _____

City, State, Zip _____

Date of Birth _____

Marital Status

☐ Divorced ☐ Married ☐ Never Married ☐ Separated ☐ Unknown ☐ Widowed

Relationship to client

☐ Adopted Child ☐ Adopted Parent ☐ Adopted Sibling ☐ Advocate ☐ Aunt
☐ Biological Parent ☐ Brother ☐ Brother-in-law ☐ Child Conservator (non-public guardian) ☐ Conservator (Public Guardian) ☐ Court ☐ Cousin ☐ Daughter ☐ Employer
☐ EMT/Ambulance ☐ Family Member ☐ Father ☐ Father-in-law ☐ Foster Child
☐ Foster Daughter ☐ Foster Father ☐ Foster Mother ☐ Foster Parent ☐ Foster Sibling
☐ Foster Son ☐ Friend ☐ Granddaughter ☐ Grandfather ☐ Grandmother
☐ Grandparent ☐ Grandson ☐ Husband ☐ Law Enforcement Official ☐ Legal Guardian
☐ Mother ☐ Mother-in-law ☐ Neighbor ☐ Nephew ☐ Next of Kin ☐ Niece ☐ Parent
☐ Primary Care Physician ☐ Provider ☐ Roommate ☐ Sibling ☐ Significant Other
☐ Sister ☐ Sister-in-law ☐ Social Services Staff ☐ Son ☐ Spouse ☐ Step-child
☐ Stepdaughter ☐ Stepfather ☐ Stepmother ☐ Step-Parent ☐ Stepson ☐ Uncle
☐ Wife ☐ Other ☐ Unknown

County of San Luis Obispo Behavioral Health
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Client Name _____ **Client ID** _____

Address

Street Address _____

City, State, Zip _____

Phone Number 1 _____ ☐ Home ☐ Mobile ☐ Other _____

☐ DNC ☐ DNLM

Phone Number 2 _____ ☐ Home ☐ Mobile ☐ Other _____

☐ DNC ☐ DNLM

Employer's Address

Street Address _____

City, State, Zip _____

Veteran Status ☐ Yes ☐ No Social Security # _____

Employer's Phone Number

Phone Number _____ ☐ Business ☐ Mobile ☐ Other _____

☐ DNC ☐ DNLM

If not employed, enter date last worked _____

Client Name _____ **Client ID** _____
Spouse First Name _____ **Spouse Last Name** _____

Spouse's Employer_____ **Spouse's Position** _____

If not employed, enter date last worked _____

Spouse's Employer's Address

Street Address _____

City, State, Zip _____

Spouse's Employer's Phone Number

Phone Number _____ ☐ Business ☐ Mobile ☐ Other _____

☐ DNC ☐ DNLM

Nearest Relative First Name_____

Nearest Relative Last Name _____

Nearest Relative's Address

Street Address _____

City, State, Zip _____

Nearest Relative's Phone Number

County of San Luis Obispo Behavioral Health
UMDAP Financial Assessment

Client Name _____ **Client ID** _____

Phone Number _____ ☐ Business ☐ Mobile

☐ Other _____

☐ DNC ☐ DNLM

Third Party Information

Insurance _____ Insurance ID _____

Medicare Policy ID Number _____ Medi-Cal CIN _____

Street Address _____

City, State, Zip _____

Assignment/Release of Information obtained ☐ Yes ☐ No

Financial Liability

Annual Period Start Date _____ **Annual Period End Date** _____

Income

Responsible Person $ _____

Spouse $ _____

Other $ _____

Total gross monthly income $ _____

Number dependent on income _____

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UMDAP Liability Determination

Liquid Assets

Savings $ _____

IRA, CD, Market Value of Stocks, Bonds and Mutual Funds $ _____

Checking accounts $ _____

Total of liquid assets $ _____

Less asset allowance $ _____

Total net liquid assets $ _____

Monthly Asset Valuation $ _____

Asset Determination

Adjusted gross monthly income $ _____

Allowable Expenses

Court ordered obligations paid monthly $ _____

Monthly child care (necessary for employment) $ _____

Monthly dependent support payments $ _____

Monthly medical expense payments $ _____

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

Client Name _____ **Client ID** _____

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

Total allowable expenses $ _____

Adjusted Monthly Income

Adjusted gross monthly income minus total allowable expenses $ _____

UMDAP Liability Determination

Annual liability $ _____

Adjusted annual liability (if applicable) $ _____

Agreed upon payment plan to satisfy the above liability $ _____

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Other Information

Provider of Financial Information (if other than the client or responsible person)

Name _____ Adjusted by _____

Approved by _____ Adjusted reason ☐ Therapeutic Exemption

Approval Date _____

An explanation of the UMDAP liability was provided. ☐ Yes ☐ No

Street Address _____

City, State, Zip _____

Responsible Party Signature _____ Date _____

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Relationship _____

Staff Signature _____ Date _____

Title _____