

**GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER
PAYOR FINANCIAL INFORMATION & FPA APPLICATION**

CONFIDENTIAL CLIENT INFORMATION

CLIENT INFORMATION

1 CLIENT NAME	SS #	CLIENT ID #
2 MAIDEN NAME	DOB	MARITAL STATUS M S D W SP
		SPOUSE NAME

THIRD PARTY INFORMATION

3 NO THIRD PARTY PAYOR <input type="checkbox"/>						
4 MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDI-CAL COUNTY CODE /AID CODE/ CLAIM #		MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE REFERRED
				REFERRED FOR ELIGIBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO		
5 SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE	IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON		
6 MEDI-CAL HMO <input type="checkbox"/> YES <input type="checkbox"/> NO	CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO	AB3632 <input type="checkbox"/> YES <input type="checkbox"/> NO	GROW <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES CIN #	OTHER FUNDING
7 MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	CHAMPUS <input type="checkbox"/> YES <input type="checkbox"/> NO	VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIVATE INS <input type="checkbox"/> YES <input type="checkbox"/> NO	HMO <input type="checkbox"/> YES <input type="checkbox"/> NO	CLAIM #
8 NAME OF CARRIER			GROUP/POLICY/ID #	NAME OF INSURED		
9 CARRIER ADDRESS					ASSIGNMENT/RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	

PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10 NAME OF PAYOR	RELATION TO CLIENT	DOB	MARITAL STATUS M S D W SP	PAYOR CDL/CAL ID
11 ADDRESS	CITY	STATE	ZIP CODE	TEL #
12 SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER: _____				PAYOR SS #
13 EMPLOYER		POSITION	IF NOT EMPLOYED, DATE LAST WORKED	
14 EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
15 SPOUSE	ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #
16 SPOUSE'S EMPLOYER		POSITION	IF NOT EMPLOYED, DATE LAST WORKED	
17 SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
18 NEAREST RELATIVE/RELATIONSHIP		ADDRESS (Include City, State & Zip Code)	TEL #	

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS Savings \$ _____ Checking Accounts \$ _____ IRA, CD, Market value of stocks, bonds and mutual funds \$ _____ TOTAL LIQUID ASSETS \$ _____ Less Asset Allowance \$ _____ Net Asset Valuation \$ _____ Monthly Asset Valuation (Divide Net Asset by 12) \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	20 ALLOWABLE EXPENSES Court ordered obligations paid monthly \$ _____ Monthly child care payments (necessary for employment) \$ _____ Monthly dependent support payments \$ _____ Monthly medical expense payments \$ _____ Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____ Total Allowable Expenses \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	21 ADJUSTED MONTHLY INCOME Gross Monthly Family Income Self/Payor \$ _____ Spouse \$ _____ Other \$ _____ TOTAL \$ _____ Add monthly asset valuation \$ _____ TOTAL \$ _____ Subtract total expenses \$ _____ Adjusted Monthly Income \$ _____ VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO
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22 Number Dependent on Adjusted Monthly Income	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD FROM TO	Payment Plan \$ _____ per month for _____ months.
23 PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)			

OTHER

24 PRIOR MH TREATMENT (Only applicable to current Annual Charge Period) <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25 ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26 An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER	PROVIDER NAME AND NUMBER		
27 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 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON		DATE	