

## FINANCIAL RESPONSIBILITY INFORMATION AND MEDI-CAL SHARE OF COST INSTRUCTIONS

### REQUIRED FORM:

This form is a required document in the client file for all San Diego County funded Substance Use Disorder programs.

### WHEN:

Completed upon admission for all clients and monthly for clients with a Medi-Cal Share of Cost (SOC).

**Reminder:** Programs must verify all clients' Medi-Cal eligibility along with any applicable SOC on a monthly basis. For additional information, refer to the **DMC Eligibility Printout** instructions in Section 1 of the Substance Use Disorder Utilization Review Management (SUDURM).

***Note:** If a client received DMC services **prior to** becoming Medi-Cal eligible, staff must inform the client to request an evaluation for retroactive Medi-Cal and assist client with applying for retroactive Medi-Cal benefits as needed. Staff should also check Medi-Cal eligibility for the prior month(s) when Drug Medi-Cal service(s) were received to verify if those services may be billed to DMC, now. (For example: Client was admitted into program 10/25/2018 with no health coverage and began receiving services during this time. On 11/15/2018, client receives a letter of approval for Medi-Cal with an effective date of 11/01/2018. Since the client received services prior to 11/01/2018, the counselor and client contact a Medi-Cal Eligibility Worker to request an evaluation for retroactive Medi-Cal for the month of October. The client is later approved for retroactive Medi-Cal for month of October and DMC services received from 10/25/2018 – 10/31/2018 can now be billed to DMC.)*

### COMPLETED BY:

Authorized agency representative or client

### REQUIRED ELEMENTS:

- **Client's name:** Complete client's first and last name.
- **Parent or authorized representative's name:** If minor, complete name of parent or authorized representative.
- **Do you and/or your family have health coverage:** Circle appropriate yes, no, or N/A answer. If client does not have health coverage, client must be provided a referral to 2-1-1 and Covered California website.
- **If answer is NO, were you provided a referral to 2-1-1 and Medi-Cal or Covered California:** Circle appropriate yes, no, or N/A answer.
- **CalWORKS recipient:** Circle appropriate yes or no answer.
- **Medi-Cal Eligible:** Circle appropriate yes or no answer.
- **Do you currently have Medi-Cal:** Circle appropriate yes or no answer.
  - If answer is YES, complete "For Medi-Cal Recipients" section below
  - If answer is NO, complete "For Non-Medi-Cal Clients" section on page 2

**For Medi-Cal Recipients:** Complete this section if client answered yes to having Medi-Cal

- **Do you have a Medi-Cal Monthly Share of Cost:** Circle appropriate yes or no answer. If YES, complete the following sections:
  - **Spend Down Amount:** Monthly amount required to meet the Share of Cost
  - **Agreed amount to pay:** Amount client agreed to pay towards the monthly Share of Cost

- **One-time payment due on:** Indicate the amount the client will pay one-time
- **Installment payment plan:** Indicate the amount client will pay and check how often
  - **Daily:** Complete with daily payment amount (if applicable)
  - **Monthly:** Complete with monthly payment amount (if applicable)
  - **Weekly:** Complete with weekly payment amount (if applicable)
  - **Others (please specify):** Complete with other payment amount and specify payment plan (if applicable)
  - **The first payment is due on and the final payment is due on:** Complete with when first and last payments are due

**Note:** For more information regarding how to handle Share of Cost, please refer to the **BHS Drug Medi-Cal Organizational Providers Billing Manual**.

**For Non-Medi-Cal Clients:** Complete this section if client answered no to having Medi-Cal

- **Number of dependent(s) on income (including self):** Complete the number of people dependent on the income of the client including self.
- **Gross Family Income (before taxes):** Complete the client's gross family income earned before taxes.
- **Court-ordered revenue and recovery expenses:** Complete total deductions taken for court ordered revenue and recovery expenses. Client may be asked to provide proof of payments.
- **Adjusted Income:** This is gross family income minus court-ordered revenue and recovery expenses.
- **Fee based on sliding scale:** Use the County Sliding Fee Scale to determine the fee. (Located in Appendix E.1 of the Substance Use Disorder Provider Operations Handbook - SUDPOH)
- **Adjusted Fee:** This is the final fee based on client's ability to pay or funding source (e.g., indigent, Medi-Cal eligible, CalWorks, third party pay).
- **Reason for fee adjustment:** This is an explanation of why client's fee was adjusted.
  
- **Check here if you were offered and provided a copy of this form:** Client must check here that they were offered and provided with a copy – **program is required to offer a copy to the client.**
- **Client Name:** Client must print full name here.
- **Client Signature and Date:** Client must sign and date affirming all statements are true and correct.
- **Parent or Authorized Representative Signature:** If minor, parent or authorized representative print name here.
- **Parent or Authorized Representative Signature:** If minor, parent or authorized representative must sign and date.
- **Completed by:** The staff completing or reviewing this form must print name, sign, and date.