

**FINANCIAL RESPONSIBILITY INFORMATION  
AND MEDI-CAL SHARE OF COST**

This form shall be completed upon admission for every client and shall be completed monthly for clients with a Medi-Cal Share of Cost (SOC).

If the client is seeking treatment without the knowledge or consent of a parent or authorized representative, the information given below should be based only on the client's financial information. If the client is seeking treatment with the knowledge and/or consent of a parent or authorized representative, the information given below should be based on the parent or authorized representative's financial information.

Client's Name: \_\_\_\_\_

Parent or authorized representative's name: \_\_\_\_\_

Do you and/or your family have health coverage?  YES  NO  N/A

Were you provided a referral to 2-1-1 and Medi-Cal or Covered California?  YES  NO

CalWORKS Recipient:  YES  NO

Medi-Cal Eligible:  YES  NO

Do you currently have Medi-Cal?  YES  NO

(If YES, complete "For Medi-Cal Recipients" section below. If NO, complete "For Non-Medi-Cal Clients" section on page 2.)

**For Medi-Cal Recipients**

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Do you have a Medi-Cal Monthly Share of Cost?  YES  NO

If YES, complete the following:

Spend Down Amount \$ \_\_\_\_\_

Agreed amount to pay \$ \_\_\_\_\_

One-time payment due on \_\_\_\_\_

Installment payment plan

Daily \$ \_\_\_\_\_  Weekly \$ \_\_\_\_\_

Monthly \$ \_\_\_\_\_  Others (please specify) \_\_\_\_\_ \$ \_\_\_\_\_

The first payment is due on \_\_\_\_\_ and the final payment is due on \_\_\_\_\_.

**NOTE:** If it has been determined to require the client to pay a minimum Share of Cost fee, the fee is owed to the program, but no service will be refused due to a client's inability to pay.

**For Non-Medi-Cal Clients**

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Number of dependents on income (*including self*):

\_\_\_\_\_

Gross Family Income (*before taxes*) \$ \_\_\_\_\_

Court-ordered revenue and recovery expenses \$ \_\_\_\_\_

*(Client may be asked to provide proof of payments)*

Adjusted income (*gross minus court expenses*) \$ \_\_\_\_\_

Fee based on sliding scale \$ \_\_\_\_\_

Adjusted fee \$ \_\_\_\_\_

Reason for fee adjustment: \_\_\_\_\_

**Indigent Clients**

It has been determined to require clients to pay a minimum fee even when indigent, although no service will be refused due to client's inability to pay, the fee is owed to the program.

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***I affirm that the statements made herein are true and correct to the best of my knowledge:***

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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***Completed by:***

Program Staff Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_