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

Please note that Medi-Cal payment is accepted as payment in full to the program.

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

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.

Check here if you were offered and provided a copy of this form ☐

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

Client Printed Name: ____

Client Signature: ____ Date: _____________________________

Authorized Representative Name: _______________________________________ Relationship: ______________________

Signature: ____ Date: _____________________________

Completed by:

Program Staff Printed Name: ____

Signature: ____ Date: _____________________________