Mendocino County Health and Human Services Agency
Behavioral Health and Recovery Services
Registration (CSI)/ UMDAP Financial Information

CLIENT NUMBER:	

☐ New ☐ Update Date: _____

Registration (CSI): **** FILL IN ALL INFORMATION BELOW****

***Client Name*:** (LAST) (FIRST) (MIDDLE)	***Date of Birth*:**
***Mailing Address*:** (Number & Street)	***SSN*:**
City State Zip	***Gender*: Male Female**
Street Address:	
***Phone*: HM:** **WK:** **CELL:**	
***Other Names Used*:**	

***Primary Care Physician: Name*:**	**Phone #:**
Advance Directive: ☐ **Yes** ☐ **No** **Last Updated:**	**Location:** ☐ **In Chart** ☐ **Other:**

Primary Language:	***Religion:***
Ethnicity/Race:*(Enter one (P) Primary, Up to 5 (S) Secondary)* _ Alaskan Native _ American Indian _ Asian Native _ African American _ Cambodian _ Chinese _ Filipino _ Guamanian _ Hawaiian _ Hispanic _ Japanese _ Korean _ Laotian _ Other _ Other Asian or Pacific Islander _ Samoan _ Unknown/Not Reported _ Vietnamese _ White	***Hispanic Origin:*** ***(Select One if applicable)*** ☐ Cuban ☐ Mexican/Mexican American ☐ Not Hispanic ☐ Other Hispanic/ Latino ☐ Puerto Rican ☐ Unknown ***Marital Status:*** ***(Select One)*** ☐ Divorced/Annulled ☐ Married ☐ Separated ☐ Single/Never Married ☐ Unknown ☐ Widowed

Mendocino County Health and Human Services Agency
Behavioral Health and Recovery Services
Registration (CSI)/ UMDAP Financial Information

CLIENT NUMBER:	

***Birth* Name:** ☐ **Same as Above**

(LAST) **(FIRST)** **(MIDDLE)**

Mother's First Name:

Place of Birth:

County **State** **Country**

Education:* *(Enter Years or Select Option)

___Enter Years (1-19)

☐ 20+ Years

☐ 1 Yr Preschool

☐ 2 Yrs or More Preschool

☐ 1 Yr Special Education

☐ 2 Yrs or More Special Education

☐ 1 Yr Vocational/Technical

☐ 2 Yrs Vocational/Technical

☐ Unknown

☐ None

Smoker:* *(Select One)

☐ Current Every Day Smoker

☐ Current Some Day Smoker

☐ Former Smoker

☐ Heavy Tobacco Smoker

☐ Light Tobacco Smoker

☐ Never Smoked

☐ Smoker, Current Status

☐ Unknown

☐ Unknown if Ever Smoked

Employment Status:* *(Select One)

☐ Full Time (32+ Hours a week, Not Including Armed Forces)

☐ Part Time (16-32 Hours a week, Not Including Armed Forces)

☐ Part Time (1-15 Hours a week, Not Including Armed Forces)

☐ In the Armed Forces

☐ Not in Labor Force-Homemaker

☐ Not in Labor-Student

☐ Not in Labor-Retired

☐ Not in Labor-Resident/Inmate of Institution

☐ Not in Labor-Unable to Work Due to MH, Developmental Disability, or A+D

☐ Not in Labor-Unable to Work Due to Other Disorder or Disability

☐ Not in Labor-Other Not Seeking Employment in last 30 days

☐ Unemployed-On Layoff From Job

☐ Unknown

Mendocino County Health and Human Services Agency
Behavioral Health and Recovery Services
Registration (CSI)/ UMDAP Financial Information

CLIENT NUMBER:	

FINANCIAL INFORMATION (UMDAP):

Care Giver: Under 18:_____ Over 18:_____

***Enter the number of persons the client cares for or is responsible for at least 50% of the time.**

Family Members:

Name	Type (Head of Household (HH); In-House Family Member (IHFM); Out-of-House Family Member (OHFM); Extended Family (EF))	Relationship to Head of Household

Insurance: (Check all that apply)*

☐ None	☐ Medi-Cal #	☐ Medicare #
☐ Private *Make a copy, front and back, of private insurance card and attach to form Insurance Name:	Group #:	Subscriber ID:
Subscriber Name:	Subscriber Phone #:	
Subscriber Birth Date:		
Subscriber Address:		

Initial:	
	I hereby assign any benefits payable to the above to Mendocino County Behavioral Health or authorized service provider. This amount is not to exceed the regular charges for this period of services.
	I authorize Mendocino County Behavioral Health or authorized service provider to bill on my behalf any and all identified commercial insurance coverage.
	I agree to be responsible for any co-pay or share of cost not covered by my insurance.

Mendocino County Health and Human Services Agency
Behavioral Health and Recovery Services
Registration (CSI)/ UMDAP Financial Information

CLIENT NUMBER:	

Number of Dependents:	

Total Gross Monthly Income: (Responsible person, Spouse, Other) (A)	Total Assets: (Checking, Savings, Stocks, Bonds) (B)	*Asset Allowance: (Dependent allowance MINUS total assets (B) DIVIDED BY 12) (C) (If no assets leave blank)	Monthly Allowable Expenses: (Court ordered fines, Child Care, Support Payments, Medical Expenses, Retirement Plans) (D)	Adjusted Gross Income (A+C-D)
$	$	$	$	$

* Dependent Allowance: (1)$1500, (2)$2250, (3)$2300, (4)$2400, (5)$2500, (6)$2600, (7)$2700

Calculated UMDAP Annual Liability (See Fee Schedule)	$

Minimum Monthly Payments	$

Responsible Party:

Name:	Relationship to Client:
Address: (Street, City, State, Zip)	
Phone:	

I acknowledge that the statements made herein are true and correct to the best of my knowledge. I understand that unless the agency has a contract with the insurance company listed to accept discounted rates, I will be held financially responsible for all fees as outlined above. Refusal to complete and sign this form may result in your being charged for services in full.

Client or Responsible Party Signature: _____Date: _____

Staff Signature: _____Date:_____

Staff Print Name: _____