

Please complete the following highlighted information:

ADMISSION – Admission Tab - Page 1	<p>NAME:</p> <p>LAST FIRST MIDDLE</p> <p>GENDER: (select one) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN/NOT RPDT</p> <p>DATE OF BIRTH: / / MM DD YYYY</p> <p>DATE OF FIRST BILLED CONTACT: / / MM DD YYYY</p> <p>LOCATION (PROGRAM): _____</p>	<p>CLIENT NUMBER: _____</p> <p>ADMITTING PRACTITIONER NAME: _____</p> <p>LAST FIRST NUMBER</p> <p>PRACTITIONER TYPE: <input type="checkbox"/> STAFF <input type="checkbox"/> CONTRACT <input type="checkbox"/> ORG PROVIDER</p> <p>CHART LOCATION: _____</p> <p>CLIENT SOCIAL SECURITY NO: _____</p>
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ADMISSION – Demographics Tab - Page 1	<p>NAME</p> <p>SUFFIX: <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V</p> <p>PREFIX: <input type="checkbox"/> DR <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS</p> <p>ADDRESS-MAILING</p> <p>ADDRESS-STREET</p> <p style="text-align:right;">ZIP CODE</p> <p style="text-align:right;">CITY</p>	<p>COUNTY: _____</p> <p>STATE: _____</p> <p>HOME PHONE: _____</p> <p>WORK PHONE: _____</p> <p>PRIMARY LANGUAGE: (circle one)</p> <table style="width:100%; border:none;"> <tr> <td>American Sign Lang</td> <td>Ilacano</td> <td>Polish</td> </tr> <tr> <td>Arabic</td> <td>Italian</td> <td>Portuguese</td> </tr> <tr> <td>Armenian</td> <td>Japanese</td> <td>Russian</td> </tr> <tr> <td>Cambodian</td> <td>Korean</td> <td>Samoan</td> </tr> <tr> <td>Cantonese</td> <td>Loa</td> <td>Spanish</td> </tr> <tr> <td>English</td> <td>Mandarin</td> <td>Tagalog</td> </tr> <tr> <td>Farsi</td> <td>Mien</td> <td>Thai</td> </tr> <tr> <td>French</td> <td>Other Chinese Lang</td> <td>Turkish</td> </tr> <tr> <td>Hebrew</td> <td>Other Non-English</td> <td>Unknown/Not Report</td> </tr> <tr> <td>Hmong</td> <td>Other Sign Lang</td> <td>Vietnamese</td> </tr> </table>	American Sign Lang	Ilacano	Polish	Arabic	Italian	Portuguese	Armenian	Japanese	Russian	Cambodian	Korean	Samoan	Cantonese	Loa	Spanish	English	Mandarin	Tagalog	Farsi	Mien	Thai	French	Other Chinese Lang	Turkish	Hebrew	Other Non-English	Unknown/Not Report	Hmong	Other Sign Lang	Vietnamese
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Hmong	Other Sign Lang	Vietnamese																														

ADMISSION – Demographics Tab - Page 2	<p>MARITAL STATUS: (select one) <input type="checkbox"/> DIVORCED/ANNULLED <input type="checkbox"/> MARRIED <input type="checkbox"/> REMARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> SINGLE/NEVER MARRIED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WIDOWED</p> <p>EDUCATION: (enter years or select option) (1 - 19) _____ Years <input type="checkbox"/> None <input type="checkbox"/> 1 Yr Preschool <input type="checkbox"/> 2 Yrs or more Preschool <input type="checkbox"/> 1 Yr Special Education <input type="checkbox"/> 2 Yrs or more Special Education <input type="checkbox"/> 1 Yr Vocational/Technical <input type="checkbox"/> 2 Yr Vocational/Technical <input type="checkbox"/> Unknown <input type="checkbox"/> 20 + Years</p> <p>EMPLOYMENT STATUS: (select one) <input type="checkbox"/> Full Time (32+ Hours A Week Not Including Armed Forces) <input type="checkbox"/> Part Time (16-32 Hours A Week Not Including Armed Forces) <input type="checkbox"/> Part Time (1-15 Hours A Week Not Including Armed Forces) <input type="checkbox"/> In The Armed Forces <input type="checkbox"/> Not In Labor Force - Homemaker <input type="checkbox"/> Not In Labor Force - Student <input type="checkbox"/> Not In Labor Force - Retired <input type="checkbox"/> Not In Labor Force - Resident/Inmate Of Institution <input type="checkbox"/> Not In Labor Force - Unable To Work Due To MH, Developmental Disability, or A+D <input type="checkbox"/> Not In Labor Force - Unable To Work Due To Other Disorder Or Disability <input type="checkbox"/> Not In Labor Force - Other Not Seeking Employment In Past 30 Days <input type="checkbox"/> Unemployed - On Layoff From Job <input type="checkbox"/> Unknown</p>	<p>USUAL OCCUPATION: (select one)</p> <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Executive, Administrative, And Managerial Occupations</td> <td><input type="checkbox"/> Extractive Occupations</td> </tr> <tr> <td><input type="checkbox"/> Professional Specialty Occupations</td> <td><input type="checkbox"/> Precision Production Occupations</td> </tr> <tr> <td><input type="checkbox"/> Technicians And Related Support Occupations</td> <td><input type="checkbox"/> Machine Operators And Tenders</td> </tr> <tr> <td><input type="checkbox"/> Sales Occupations</td> <td><input type="checkbox"/> Fabricators, Assemblers, And Handworking Occupations</td> </tr> <tr> <td><input type="checkbox"/> Administrative Support Occupations Including Clerical</td> <td><input type="checkbox"/> Production Inspectors, Testers, Samplers And Weighers</td> </tr> <tr> <td><input type="checkbox"/> Private Household Occupations</td> <td><input type="checkbox"/> Transportation And Material Moving Occupations</td> </tr> <tr> <td><input type="checkbox"/> Protective Service Occupations</td> <td><input type="checkbox"/> Handlers, Equipment Cleaners, Helpers, And Laborers</td> </tr> <tr> <td><input type="checkbox"/> Service Occupations, Except Protective And Household</td> <td><input type="checkbox"/> Military Occupations</td> </tr> <tr> <td><input type="checkbox"/> Farming, Forestry, And Fishing Occupations</td> <td><input type="checkbox"/> Preschooler Or Student</td> </tr> <tr> <td><input type="checkbox"/> Mechanics And Repairs</td> <td><input type="checkbox"/> Never Employed</td> </tr> <tr> <td><input type="checkbox"/> Construction Trades</td> <td><input type="checkbox"/> Unknown</td> </tr> </table> <p>OTHER NAMES USED: _____</p> <p>Start Date of UMDAP Year: (MM/DD/YY) _____</p> <p>End Date of UMDAP Year: (MM/DD/YY) _____</p> <p>Comments: _____</p>	<input type="checkbox"/> Executive, Administrative, And Managerial Occupations	<input type="checkbox"/> Extractive Occupations	<input type="checkbox"/> Professional Specialty Occupations	<input type="checkbox"/> Precision Production Occupations	<input type="checkbox"/> Technicians And Related Support Occupations	<input type="checkbox"/> Machine Operators And Tenders	<input type="checkbox"/> Sales Occupations	<input type="checkbox"/> Fabricators, Assemblers, And Handworking Occupations	<input type="checkbox"/> Administrative Support Occupations Including Clerical	<input type="checkbox"/> Production Inspectors, Testers, Samplers And Weighers	<input type="checkbox"/> Private Household Occupations	<input type="checkbox"/> Transportation And Material Moving Occupations	<input type="checkbox"/> Protective Service Occupations	<input type="checkbox"/> Handlers, Equipment Cleaners, Helpers, And Laborers	<input type="checkbox"/> Service Occupations, Except Protective And Household	<input type="checkbox"/> Military Occupations	<input type="checkbox"/> Farming, Forestry, And Fishing Occupations	<input type="checkbox"/> Preschooler Or Student	<input type="checkbox"/> Mechanics And Repairs	<input type="checkbox"/> Never Employed	<input type="checkbox"/> Construction Trades	<input type="checkbox"/> Unknown
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Please complete the following highlighted information:

Client # _____

Admission – CSI Tab - Page 1

Client's Birth Name:

Last _____ First _____ Middle _____

Mother's First Name: _____

Client's Place of Birth:

County: (circle one)		State: (circle one)
Not California County	Orange	00= Not US State
Alameda	Placer	AK= Alaska
Alpine	Plumas	AL= Alabama
Amador	Riverside	AR= Arkansas
Butte	Sacramento	AZ= Arizona
Calaveras	San Benito	CA= California
Colusa	San Bernardino	CO= Colorado
Contra Costa	San Diego	CT= Connecticut
Del Norte	San Francisco	DC= District of Columbia
El Dorado	San Joaquin	DE= Delaware
Fresno	San Luis Obispo	FL= Florida
Glenn	San Mateo	GA= Georgia
Humboldt	Santa Barbara	HI= Hawaii
Imperial	Santa Clara	IA= Iowa
Inyo	Santa Cruz	ID= Idaho
Kern	Shasta	IL= Illinois
Kings	Sierra	IN= Indiana
Lake	Siskiyou	KS= Kansas
Lassen	Solano	KY= Kentucky
Los Angeles	Sonoma	LA= Louisiana
Madera	Stanislaus	MA= Massachusetts
Marin	Sutter	MD= Maryland
Mariposa	Tehama	ME= Maine
Mendocino	Trinity	MI= Michigan
Merced	Tulare	MN= Minnesota
Modoc	Tuolumne	MO= Missouri
Mono	Ventura	MS= Mississippi
Monterey	Yolo	MT= Montana
Napa	Yuba	NC= North Carolina
Nevada	Unknown County	ND= North Dakota
		NE= Nebraska
		NH= New Hampshire
		NJ= New Jersey
		NM= New Mexico
		NV= Nevada
		NY= New York
		OH= Ohio
		OK= Oklahoma
		OR= Oregon
		PA= Pennsylvania
		RI= Rhode Island
		SC= South Carolina
		SD= South Dakota
		TN= Tennessee
		TX= Texas
		UN= Unknown State
		UT= Utah
		VA= Virginia
		VT= Vermont
		WA= Washington
		WI= Wisconsin
		WV= West Virginia
		WY= Wyoming

Country: _____

Ethnicity/Race Primary: (circle one)

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

Ethnicity/Race Secondary: (Circle one if Applicable):

Alaskan Native
American Indian
Asian Native
African American
Cambodian
Chinese
Filipino
Guamanian
Hawaiian
Hispanic
Japanese
Korean
Laotian
Other
Other Asian or Pacific Islander
Samoan
Multiple
Vietnamese
White

SMOKER: (select one)

Current Everyday Smoker
 Current Some Day Smoker
 Current Status Unknown
 Former Smoker
 Heavy Tobacco Smoker
 Light Tobacco Smoker
 Never Smoked
 Smoker
 Unknown if Ever Smoked

STAFF MEMBER COMPLETING FORM: _____ DATA ENTRY _____

HEALTH AND HUMAN SERVICES AGENCY – MENTAL HEALTH **REGISTRATION/UMDAP FORM**

Please complete the following **highlighted** information:

Staff will assist in filling in the following areas:

Client # _____

FINANCIAL ELIGIBILITY – Guarantor Selection Tab – Page 1

MEDI-CAL / MEDICARE / INSURANCE INFORMATION (1)

Insurance Name (Guarantor)	Insurance Address - ZipCode	_____
Insurance Address-Line 1	Insurance Address – City	_____
Insurance Address-Line 2	Insurance Address – State	_____
	Insurance Phone Number	_____
	Inhibit Billing by Mail	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Effective Date of Contract (mm/dd/yyyy)	_____
	Expiration Date of Contract (mm/dd/yyyy)	_____

FINANCIAL ELIGIBILITY – Guarantor Selection Tab – Page 2

Eligibility Verified <input type="checkbox"/> Yes <input type="checkbox"/> No	Subscriber Address - ZipCode	_____
Coverage Effective Date (mm/dd/yyyy) _____	Subscriber Address– City	_____
Coverage Expiration Date (mm/dd/yyyy) _____	Subscriber Address– County	_____
Clients Relationship to Subscriber: (select one)	Subscriber Phone Number	_____
<input type="checkbox"/> Self <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Grandfather <input type="checkbox"/> Grandmother	Subscriber Social Security #	_____
<input type="checkbox"/> Stepfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Foster Father <input type="checkbox"/> Foster Mother <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Subscriber Birth Date	_____
<input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Employer <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	(mm/dd/yyyy)	
<input type="checkbox"/> Foster Son <input type="checkbox"/> Foster Daughter <input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Court <input type="checkbox"/> Unknown	Subscriber Employer Name:	_____
Subscriber's Name:		
Subscriber Address – Line 1		
Subscriber Address – Line 2		

FINANCIAL ELIGIBILITY – Guarantor Selection Tab – Page 3

Subscriber Employer ID Number: _____	Client's Medi-Cal # _____
Subscriber Employer Address –Street: _____	Client's Branch/Service _____
Subscriber Employer Address –Zip: _____	(if Military)
Subscriber Employer Address –City: _____	Client's Military Status _____
Subscriber Employer Address –County: _____	
Subscriber Employer Address –State: _____	
Subscriber Work Phone: _____	
Subscriber Group Name: _____	
Subscriber Group Number: _____	
Subscriber Policy # _____	
Client Medicare # _____	

Subscriber Assignment of Benefits Yes No

Subscriber Release of Information Yes No

Coordination of Benefits Yes No

To be completed by Finance Staff

Date Benefits Terminate: _____
(mm/dd/yyyy)

I authorize the release of medical or other information necessary to process insurance, Medicare, Medi-Cal and similar claims. I authorize payment of medical benefits to Mendocino County Mental Health Services.

Subscribers Signature: _____ Date: _____

Staff Name/Date: _____ Data Entry: _____

Please complete the following **highlighted** information:

Staff will assist in filling in the following areas:

Client # _____

FINANCIAL ELIGIBILITY – Guarantor Selection Tab – Page 1

SECONDARY INSURANCE INFORMATION IF APPLICABLE (use sheet if needed)

Insurance Name (Guarantor) _____ Insurance Address - ZipCode _____

Insurance Address-Line 1 _____ Insurance Address – City _____

Insurance Address-Line 2 _____ Insurance Address – State _____

Insurance Phone Number _____

Inhibit Billing by Mail Yes No

Effective Date of Contract (mm/dd/yyyy) _____

Expiration Date of Contract (mm/dd/yyyy) _____

FINANCIAL ELIGIBILITY – Guarantor Selection Tab – Page 2

Eligibility Verified Yes No

Coverage Effective Date (mm/dd/yyyy) _____

Coverage Expiration Date (mm/dd/yyyy) _____

Clients Relationship to Subscriber: (select one)

Self Father Mother Wife Husband Grandfather Grandmother

Stepfather Stepmother Foster Father Foster Mother Son Daughter

Stepson Stepdaughter Legal Guardian Employer Aunt Uncle

Foster Son Foster Daughter Grandson Granddaughter Court Unknown

Subscriber's Name: _____

Subscriber Address – Line 1 _____

Subscriber Address – Line 2 _____

Subscriber Address - ZipCode _____

Subscriber Address– City _____

Subscriber Address– County _____

Subscriber Phone Number _____

Subscriber Social Security # _____

Subscriber Birth Date (mm/dd/yyyy) _____

Subscriber Employer Name: _____

FINANCIAL ELIGIBILITY – Guarantor Selection Tab – Page 3

Subscriber Employer ID Number: _____

Subscriber Employer Address -Street _____

Subscriber Employer Address -Zip _____

Subscriber Employer Address -City _____

Subscriber Employer Address -County _____

Subscriber Employer Address -State _____

Subscriber Work Phone _____

Subscriber Group Name _____

Subscriber Group Number _____

Subscriber Policy # _____

Client Medicare # _____

Client's Medi-Cal # _____

Client's Branch/Service _____

(if Military)

Client's Military Status _____

Subscriber Assignment of Benefits Yes No

Subscriber Release of Information Yes No

Coordination of Benefits Yes No

To be completed by Finance Staff

Date Benefits Terminate: _____

(mm/dd/yyyy)

I authorize the release of medical or other information necessary to process insurance, Medicare, Medi-Cal and similar claims. I authorize payment of medical benefits to Mendocino County Mental Health Services.

Subscribers Signature: _____ Date: _____

Staff Name/Date: _____ Data Entry: _____

Please complete the following **highlighted** information:

UMDAP REGISTRATION

Staff will assist in filling in the following areas:

Client # _____

FAMILY REGISTRATION - Family Registration Tab - Page 1

Responsible Party (RP) Name:

 Last First Middle

 Street Address

 Mailing Address

 Zip City State

FAMILY REGISTRATION - Family Members Tab - Page 1

Client ID/Name: _____
 - Optional -

Family/Household Members:	Type of Family Member: (circle one for each member)
_____	Head of Household Family Member (In Household) Family Member (Out of Household) Extended Family Member
_____	Head of Household Family Member (In Household) Family Member (Out of Household) Extended Family Member
_____	Head of Household Family Member (In Household) Family Member (Out of Household) Extended Family Member
_____	Head of Household Family Member (In Household) Family Member (Out of Household) Extended Family Member
_____	Head of Household Family Member (In Household) Family Member (Out of Household) Extended Family Member

Start Date Of Family Membership: ____ / ____ / ____
 MM DD YYYY

FAMILY REGISTRATION - UMDAP Information Tab - Page 1	Start Date of UMDAP Year: (MM/DD/YY) _____ End Date of UMDAP Year: (MM/DD/YY) _____ Financial Liability: Monthly Income Responsible Person: _____ Gross Monthly Income Spouse: _____ Gross Monthly Income Other: _____ A. Total Gross Monthly Income: _____ (Information needed in TOTALS on next page) Total Dependent on Income: _____	FAMILY REGISTRATION - UMDAP Information Tab - Page 2	Asset Determination: Savings Balances _____ Bank Balances _____ Market Value: Of Stocks _____ Of Bonds _____ Of Mutual Savings _____ Of Other _____ B. Total of Liquid Assets _____ C. Asset Allowance From UMDAP Schedule Dependent: 1 \$1500 3 \$2300 5 \$2500 7 \$2700 9 \$2900 2 \$2250 4 \$2400 6 \$2600 8 \$2800 Enter on line D. below (B Total Liquid Assets - C Asset Allowance) ÷ 12 D. Total Net Liquid Monthly Assets _____ [D. Information needed in B) TOTALS on next page]
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Please complete the following **highlighted** information:

Client # _____

Staff will assist in filling in the following areas:

FAMILY REGISTRATION - UMDAP Information Tab - Page 3

Allowable Monthly Expenses:

Court Ordered Obligations (fines)	_____
Child Care	_____
Dependent Support Payments	_____
Medical Expense Payments	_____
Amount of Medical Expenses Excluded	_____ 0 _____
Less Allowed Medical Expenses	_____ 0 _____
Deductions for Retirement Plans	_____
C) Total Monthly Expenses (Information needed in TOTALS below)	_____

FAMILY REGISTRATION - UMDAP Information Tab - Page 4

TOTALS

A) Total (Gross Monthly Income)	_____
B) D. Total (Monthly Liquid Assets)	_____
Total (Gross Monthly Income and Monthly Liquid Assets) (A+B)	_____
C) Total (Allowable Expenses)	_____
Adjusted Gross Income (A+B-C)	_____
Calculated UMDAP Annual Liability	_____
UMDAP Annual Liability (Enter information found above in Calculated UMDAP)	_____
Agreed Monthly Payments To Satisfy Above Liability	_____
Adjusted by	_____
Reason _____	_____
_____	_____
Approved By: _____	Interviewer: _____
Date Approved (MM/DD/YY) _____	Date Interviewed (MM/DD/YY) _____

Financial Agreement: Annual Liability \$ _____ to be paid in (# of) _____ installments of \$ _____
Each and paid in full by (MONTH/YEAR) ____ / ____ (or full cost of service minus insurance payments).

I acknowledge that the statements made herein are true and correct to the best of my knowledge. I agree to pay fees as outlined above. I authorize the release of medical or other information necessary to process Insurance, Medicare, Medi-Cal and similar claims. I authorize payment of medical benefits to Mendocino County Mental Health Services.

Client or RP Signature: _____ Staff: _____ Date: _____
Provider of Financial Information (if other than patient or responsible person)

NAME: _____
ADDRESS: _____

Provider of Financial Information Signature: _____
Data Entry: _____