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

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.

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: ___________________________

Completed by:

Program Staff Name: ________________________________________________

Signature: _________________________________________________________ Date: ___________________________