Financial Information
(Family ATP/UMDAP)

Client MRN/ID ______________________

Client Last Name ______________________ **Client First Name** ______________________

FAMILY ATP

Income Type: ☐ Self ☐ Parent / Spouse ☐ Other

Gross Monthly Income (Except foster care children): $ __________

Number of Dependents ________

Asset Allowance (Checking, savings, stocks, bonds, etc.): ☐ Checking ☐ Savings ☐ Other $ __________

Court ordered obligations paid monthly $ __________

Monthly child care (necessary for employment) $ __________

Monthly dependent support payments $ __________

Monthly medical expense payments (in excess of 2% of gross income) $ __________

Monthly mandated deductions from gross income for retirement plans (not Social Security) $ __________

PAYOR

Insurance: (check all that apply)

☐ None ☐ Medi-Cal ☐ Medicare ☐ CCHP Insured Last Name: ______________________

Insurance ID (CIN, SSN, CCHP ID, Medi-Care #): ______________________ Consumer Relation to Insured: ______________________

☐ Private Insurance Name: ______________________

Group #: ______________________ Insurance ID: ______________________

INSURED (if other than Self)

Subscriber Name: ______________________ Subscriber SS#: ______________________

Subscriber Birth Date: ______________________ Phone# ______________________

Subscriber Address: ______________________

Initial	
	I hereby assign any benefits payable by the above to Contra Costa County Health Services. This amount is not to exceed the regular charges for this period of services.
	I authorize the county to bill on my behalf any and all identified commercial insurance coverage.
	[For Educationally Related Mental Health Services only] I give my permission for private insurance to be billed. This is a necessary step prior to billing other health coverage such as Medi-Cal for reimbursement. The school district will be billed for any charges denied reimbursed by private insurance or Medi-Cal.

☐ Form completed by Telephone during COVID-19 Shelter-in-Place. Date & Time Collected: ______________________

Information provided by: ______________________

______________________ ______________
Responsible Party/Legal Guardian Signature Date

****Child and Family Services is the responsible party for children in Foster Care. The social worker must sign in the Responsible Party section as the representative.***

______________________ ______________
Staff Signature Date

Office Use Only

Family ATP/UMDAP Liability Period: ______________ Effective Date ______________

Expiration Date: ______________ Family ID #: ______________ UMDAP Liability: ______________

Reviewed By: ______________ Date: ______________ Computer Entry Clerk Initials: ______________