1127–CLIENT INFORMATION FORM-MCO

CLIENT INFORMATION (Please print):

1. Legal Name _____ Gender____ Birth date_____
   Last First M.I. Suffix mm/dd/yyyy
2. Mailing Address_____ City _____ State ___ Zip _____
3. Residential Address_____ City _____ State ___ Zip _____
   (if different from Mailing Address)
4. Home Phone_____ Work Phone_____ Cell Phone_____
5. Phone Communication Preference: ☐Home ☐Work ☐Cell
   Email_____ (please note clients cannot be contacted via email at this time)
6. Social Security Number: _____

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7. **I hereby consent to evaluation and treatment by Humboldt County Department of Health and Human Services—Behavioral Health as prescribed by the attending physician and/or professionals.**
   Client Signature_____ Date _____ Time _____
   Guardian/Resp. Party Signature_____ Date _____ Time _____

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8. **Living Arrangement:**

☐Residential/Rehabilitation Facility
☐Board & Care
☐Community Treatment Facility
☐Foster Family Home
☐Group Home (incl. levels 1-12 for children)
☐Homeless
☐House, Apartment, Trailer, Dorm, Barracks, Hotel
☐House/Apartment, daily supervision (adults)
☐House/Apartment, support w/daily activities (adults)
☐Psychiatric Hospital/Health Facility, VA Hospital
☐Juvenile Hall, CYA Home, Correctional Facility, Jail
☐Mental Health Rehabilitation Center (24 hr)
☐Other _____
☐Residential Treatment Center
☐Skilled Nursing/Intermediate Care Facility OR Institute of Mental Disease
☐State Hospital
☐Support Housing (adults only)
☐Decline to State

9. **Primary Language (check one):**

☐American Sign Language
☐Arabic
☐Armenian
☐Cambodian
☐Cantonese
☐English
☐Farsi
☐French
☐Hebrew
☐Hmong
☐Ilocano
☐Italian
☐Japanese
☐Korean
☐Lao
☐Mandarin
☐Mien
☐Other Chinese Language
☐Other Non-English
☐Other Sign Language
☐Polish
☐Portuguese
☐Russian
☐Samoan
☐Spanish
☐Tagalog
☐Thai
☐Turkish
☐Unknown/Not Reported
☐Vietnamese
☐Decline to State

Is this your Preferred Language? ☐Yes ☐No

If no, please indicate your preferred language_____

10. **Race (please check up to 5 if needed):**

☐Alaskan Native
☐American Indian
☐Asian Native
☐Black/African-American
☐Cambodian
☐Chinese

☐Filipino ☐Japanese ☐Other Asian ☐Vietnamese
☐Guamanian ☐Korean ☐Other Race ☐White
☐Hawaiian ☐Laotian ☐Samoan ☐Decline to State

What is your primary race? _____

11. What is your Ethnic Origin (check one)?

☐Cuban ☐Not Hispanic ☐Puerto Rican ☐Unknown
☐Mexican/Mexican-American ☐Other Hispanic/Latino ☐Decline to State

12. What is your Religious Preference (check one)?

☐Amish ☐Church of God ☐Jewish ☐Pentecostal
☐Assembly of God ☐Episcopal ☐Lutheran ☐Presbyterian
☐Atheist ☐Greek Orthodox ☐Mennonite ☐Protestant
☐Baha'i ☐Hindu ☐Methodist ☐Seventh-Day Adventist
☐Baptist ☐Interdenominational ☐Mormon ☐Unknown
☐Buddhist ☐Indigenous Religious/ Spiritual Practices ☐Nazarene
☐Catholic ☐Non-Denominational
☐Christian ☐Islam ☐Other (specify)
☐Church of Christ ☐Jehovah's Witness _____

13. Birth Place: City_____ State___ County_____ Country_____

14. Mother's Name: First_____ Last_____ Maiden_____

15. Marital Status (check one):

☐Abandoned ☐Married ☐Unknown
☐Divorced/Annulled ☐Remarried ☐Widowed
☐Domestic Partners ☐Separated
☐Living Together ☐Single/Never Married

16. Highest School Grade Completed: _____

17. Employment Status:

☐Full-time (32+ hrs/week)
☐In the Armed Forces
☐Homemaker
☐Not seeking work in past 30 days
☐Resident/Inmate of Institution
☐Retired
☐Student
☐Unable to Work due to behavioral health disability
☐Unable to Work due to other disorder or disability
☐Part-time (1-15 hrs/week)
☐Part-time (16-32 hrs/week)
☐Unemployed – Laid off
☐Unemployed – Seeking employment
☐Decline to State

18. Occupation:

☐Executive, Administrative, Managerial
☐Farming, Forestry, Fishing
☐Machine Operators & Tenders, except precision
☐Production, Craftsman, Laborer, etc.
☐Sales, Customer Service
☐Unemployed
☐Decline to State/Not Collected

19. Do you Smoke?

☐Current, Every Day Smoker
☐Current, Some Day Smoker
☐Current Smoker, Amount Unknown
☐Former Smoker
☐Heavy Tobacco Smoker
☐Light Tobacco Smoker
☐Never Smoked
☐Never Smoked
☐Smoker
☐Decline to State

20. Previous Names Used_____

21. Birth Name (if different from Legal Name)_____
Last First M.I. Suffix

22. What county do you currently reside in (fiscally responsible county)? _____

23. Conservatorship:

- ☐ Temporary Conservatorship
- ☐ Lanterman-Petris-Short
- ☐ Murphy
- ☐ Probate
- ☐ PC 2974
- ☐ Representative Payee without Conservatorship
- ☐ Juvenile Court, Dependent of the Court
- ☐ Juvenile Court, Ward–Status Offender
- ☐ Juvenile Court, Ward–Juvenile Offender
- ☐ Not Applicable
- ☐ Decline to State/Unknown

If Yes: Name_____ Address_____ Phone_____

24. Are you responsible for or provide care for anyone at least 50% of the time? ☐ No ☐ Yes
If yes, how many of them are between ages 0-17?__ How many of them are age18 and over?__

25. Driver's License #_____ Issuing State: _____

26. Are you a veteran? ☐ No ☐ Yes ☐ Decline to State ☐ Unknown

27. Have you or any family member been part of the Armed Forces/Reserves? ☐ No ☐ Yes (*if yes, obtain form CW5 at front desk with instructions to assist in determining your benefits*)

28. Emergency Contact:
Name_____ Relationship_____
Street_____ City_____ State___ Zip_____ Phone_____

29. Primary MD's Name/Phone_____
Who referred you here? ☐ Primary MD ☐ Other_____

30. Have you received behavioral health treatment? ☐ No ☐ Yes, but not now ☐ Yes, currently
If yes, where?_____ Under what name?_____

31. Do you have an active Workers' Compensation case? ☐ No ☐ Yes (*if yes, complete #40*)

32. Client Financial/UMDAP (Uniform Method to Determine Ability to Pay):
Source of Income:
☐ None ☐ Employment ☐ Disability ☐ GR/Public Assistance ☐ Retired ☐ Other/VA/Alimony/etc.
Employer _____ Employer's Phone_____
Spouse's Employer _____ Employer's Phone_____

Number of people in household:	UMDAP Exp. Date:	Liability Amount: $
Monthly Income (amount/source)	Assets	Monthly Expenses (not rent/utilities)
1. Self:	1. Savings:	1. Court Ordered:
2. Parent/Spouse:	2. Other (Interest/Dividends):	2. Child Care:
3. Other:		3. Dependent Support:
		4. Medical: (Ins. prem/prescriptions/doctors)
		5. Retirement: (retirement contributions)
Total Monthly Income:	Total Assets:	Total Monthly Expenses:

1127 continued Name _____ Client ID _____ Date _____

33. Responsible Party: ☐ **Self/Client** ☐ **Next of Kin/Conservator** ☐ **Other**_____

Name_____ Relationship_____

Billing Address ☐ Same as Client ☐ Same as Next of Kin/Conservator ☐ Different, send bill to:

Street_____ City_____ State___ Zip_____ Phone_____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Student ☐ None ☐ Other_____

Employer _____ Employer's Phone_____

HEALTH INSURANCE *(Attach copies of insurance cards, front and back)*

34. Medi-Cal #_____ Issue Date_____ CIN #_____

Medicare #_____ Part A Eff. Date_____ Part B Eff. Date_____

Is Medicare: ☐ Primary ☐ Secondary *Complete Advance Beneficiary Notice if pt. has Medicare.*

35. Primary Insurance Information:

Policy Holder's Name_____ Relation to Client_____

DOB_____ Gender_____ Employer_____

Effective Date_____ Policy holder ID_____ Group Name/Number_____

Company/Plan Name_____ Phone _____

Street_____ City_____ State_____ Zip_____

36. Other Insurance Information:

Policy Holder's Name_____ Relation to Client_____

DOB_____ Gender_____ Employer_____

Effective Date_____ Policy holder ID_____ Group Name/Number_____

Company/Plan Name_____ Phone _____

Street_____ City_____ State_____ Zip_____

TREATMENT & BILLING AUTHORIZATION

I hereby consent to evaluation and treatment by Humboldt County Department of Health and Human Services—Behavioral Health (DHHS-BH) as prescribed by the attending physician and/or other professionals. I further authorize the release of any medical information necessary to process this claim for Medi-Cal, Medicare, and/or insurance and I authorize payment of these benefits to DHHS-BH. By signing this document I give DHHS-BH authorization to verify any information contained on this form and to obtain any other information to determine my financial liability. I also understand that I am responsible to pay DHHS-BH for charges as calculated under the State of California's UMDAP sliding scale system.

37. Client Signature_____ Date/Time_____

38. Guardian/Responsible Party Signature_____ Date/Time_____

Staff Instructions: **Original** to patient Chart, **Copy** to Business Office (initials: _____)