DEPARTMENT OF HEALTH AND HUMAN SERVICES - BEHAVIORAL HEALTH

CLIENT INFORMATION FORM
ANNUAL UPDATE/CHANGE FORM

(PLEASE PRINT CLEARLY)

For Staff Use Only
Client Name: _____
Client ID:_____ DOB:_____

Client Name: _____ **SSN**: _____ **Case#:** _____

Name on Birth Certificate: Last: _____ First: _____ Middle:_____Suffix: ____

Place of Birth: County: _____ State: ____Country: _____ Mother First Name: _____

NAME UPDATE/CHANGES

Legal Name Change: Last Name: _____ First Name: _____ MI: _____

AKA Name Update/Changes: _____

ADDRESS UPDATE/CHANGES

Street/Residence Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Ph: _____ Work Ph: _____ Employer: _____ Employer Phone #: _____

SIGNIFICANT OTHER/EMERGENCY CONTACT UPDATE/CHANGES

Name:_____ Type of Contact: _____Relationship:_____

Address/City/State/Zip: _____Phone: _____

FINANCIAL/UMDAP INFORMATION CHANGES/ANNUAL UPDATE ***(attach copies of all cards front & back)***

Responsible Party Name: _____ Relationship to Client: _____

Address/City/State/Zip: _____ Home Phone:_____

Work Phone: _____ Employer (Name): _____ Spouse's Employer: _____

# IN HOUSEHOLD:_____	**Monthly Assets**	**Monthly Expenses (not rent/utilities)**
Monthly Income (amount/source)	Savings:	Court Ordered:
Self:	Interest:	Child Care:
Spouse:	Dividends:	Dependant Support:
Parent:	Other:	Medical (ins. premiums/prescriptions/doctors):
Other:		Retirement Contributions:
Total Monthly Income: $	Total Monthly Assets: $	Total Monthly Expenses: $

Medi-Cal #: _____ Issue date: _____Source of Income: _____

Medicare #: _____ Effective Date: Part A: _____ Part B: _____ Medicare: [ ]Primary [ ]Sec

Primary Insurance/Contract Information

Effective Date: _____ Policyholder ID#: _____ Group/Plan #: _____

Plan Name: _____ Policyholder's Name: _____

Address:_____ Phone #: _____Relation to Client: _____

DOB: _____ Gender/Sex: _____ Employer: _____

Secondary Insurance/Contract Information

Effective Date: _____ Policyholder ID#: _____ Group/Plan #: _____

Plan Name: _____ Policyholder's Name: _____

Address:_____ Phone #: _____Relation to Client: _____

DOB: _____ Gender/Sex: _____ Employer: _____

PLEASE SIGN BELOW:

I hereby consent to evaluation & treatment by Humboldt County Behavioral Health as prescribed by the attending physician and/or other professionals. I further authorize Humboldt County Behavioral Health to bill directly for services received, and to release any information requested by insurance companies and/or Medicare for claims billed on my behalf. I also authorize payments of medical benefits directly to Humboldt County Behavioral Health for all services they provided. I also understand that I am responsible to pay Humboldt County Behavioral Health for charges as calculated under the State of California UMDAP sliding fee scale system.

Client Signature: _____ **Guardian/Resp Party Signature:** _____**Date:** _____

Staff Instructions: Sent to Med Rec -([ ] sent/initials:_____) Sent to Billing Office ([ ] sent/initials: _____)