Behavioral Health and Recovery Services - Financial Responsibility Form

Client # _____ Facility Program _____

Client Last Name _____ First Name _____ Middle Initial _____

Address _____ Apartment _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____ Social Security Number _____ Driver License # _____

Sex ☐ Male ☐ Female ☐ Other ☐ Employed ☐ Unemployed ☐ Retired ☐ Other

Person Financially Responsible for Client ☐ Self ☐ Rep Payee/Conservator ☐ Other

If Other, Name _____ Relationship _____

Address _____ Apartment _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Monthly Family Gross Income (Including SSI, Disability, Unemployment, etc.) **Number of Dependents** (Incl. Self) _____

Monthly Income		**Total Assets**		**Monthly Expenses**	
Self		Checking		Court Ordered	
Parent/Spouse		Savings		Child Care	
Other		Other		Dependent Support Payments	
				Retirement Payments	
				Medical	
Total Income	$	Total Assets	$	Total Expenses	$

Health Insurance Information (Must be completed if client has health insurance)

Medi-Cal/CMSP # _____ **Medicare #** _____

Primary Carrier		**Secondary Carrier**	
Insurance Company		Insurance Company	
ID #		ID #	
Group #		Group #	
Effective Date		Effective Date	
Insured Name	Insured DOB	Insured Name	Insured DOB
Claim Address		Claim Address	

I hereby authorize payment directly to County of Marin Behavioral Health and Recovery Services for all applicable insurance benefits which I am entitled. Authorization to bill will be effective from the first date of service rendered by BHRS. I hereby authorize BHRS to furnish any and all information contained in, or disclosed by the records of BHRS to respective insurance companies to the extent necessary to satisfy claims for reimbursement of services rendered. I understand that I am financially responsible for all charges including those not fully reimbursed by my insurance carrier within the limits determined by the County of Marin in examining my ability to pay. **If I refuse to provide income information, I will be charged for the full cost of my services**. A photocopy of this document is to be considered as valid as an original.

Client Signature _____ Date _____

Authorized Representative _____ Relationship _____

Billing Staff Only Annual Liability $ _____ Annual Liability Date _____

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