**Behavioral Health and Recovery Services - Financial Responsibility Form**
**FOR FOSTER/ADOPTIVE CLIENTS ONLY**

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 ______________________