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| **AGENCY COMPLETING FORM:** | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **CLIENT NAME:** | | | | |  | | | | | | | | | |  | | | | | | | |  | |
|  | | | | | Last | | | | | | | | | | First | | | | | | | | Middle | |
| **PRIMARY GUARANTOR:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
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| **SECONDARY GUARANTOR:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
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| **MEDI-CAL VERIFIED:** | | | | | | |  | **YES** | | | | | | | |  | | | | **NO** | | | | |
|  | |  | | | | | | | | |  | | |  | | | | | | |  | | |  |
| **ADMIT DATE:** | | | | |  | | | | | | | | | |  | | |  | | | | | | |
|  | | | | | Month | | | | | | | | | | Day | | | Year | | | | | | |
| **SUBSCRIBER NAME:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
|  | | | | | | |  | |  | | | | | | | | | | | | | | | |
| **RELATIONSHIP TO SUBSCRIBER:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
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| **SUBSCRIBER ADDRESS:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
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| **SUBSCRIBER ZIP:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
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| **SUBSCRIBER CITY:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
| **SUBSCRIBER COUNTY:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
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| **SUBSCRIBER STATE:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
| **SUBSCRIBER HOME PHONE:** | | | | | |  | | | | | | | **SUBSCRIBER WORK PHONE:** | | | | |  | | | | | | |
| **SUBSCRIBER SSN:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | |  | | |  | | | | | | |  | | |  |
| **SUBSCRIBER SEX:** | | | | | | |  | **MALE** | | | | | | | |  | | | | **FEMALE** | | | | |
|  | |  | | | | | | | | |  | | |  | | | | | | |  | | |  |
| **SUBSCRIBER DOB:** | | | | |  | | | | | | | | | |  | | |  | | | | | | |
|  | | | | | Month | | | | | | | | | | Day | | | Year | | | | | | |
| **SUBSCRIBER GROUP #:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
| **SUBSCRIBER POLICY / CIN #:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
| **SUBSCRIBER MEDICARE #:** | | | | | | |  | |  | | | | | | | | | | | | | | | |
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I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND AND ACCEPT TO PAY THE AMOUNT DUE ON A TIMELY BASIS, INCLUDING MEDI-CAL SHARE OF COST. I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS CLAIMS FOR INSURANCE, MEDICARE AND/OR MEDI-CAL, AND I AUTHORIZE PAYMENT OF THESE BENEFITS TO YOLO COUNTY ALCOHOL, DRUG AND MENTAL HEALTH SERVICES. I HAVE BEEN OFFERED A COPY OF THIS FORM.

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|  |  |  |  |  |
| **Signature (Consumer or Responsible Party)** |  | **Date** |  | **Completed and Witnessed By** |