|  |  |
| --- | --- |
| **AGENCY COMPLETING FORM:** |  |
|  |  |  |  |  |  |
| **CLIENT NAME:** |  |  |  |
|  | Last | First | Middle |
| **PRIMARY GUARANTOR:** |  |  |
|  |  |  |  |  |  |
| **SECONDARY GUARANTOR:** |  |  |
|  |  |  |  |  |  |
| **MEDI-CAL VERIFIED:**  |  | **YES** |  | **NO** |
|  |  |  |  |  |  |
| **ADMIT DATE:** |  |  |  |
|  | Month | Day | Year |
| **SUBSCRIBER NAME:** |  |  |
|  |  |  |
| **RELATIONSHIP TO SUBSCRIBER:** |  |  |
|  |  |  |  |  |  |
| **SUBSCRIBER ADDRESS:** |  |  |
|  |  |  |  |  |  |
| **SUBSCRIBER ZIP:** |  |  |
|  |  |  |  |  |  |
| **SUBSCRIBER CITY:** |  |  |
| **SUBSCRIBER COUNTY:** |  |  |
|  |  |  |  |  |  |
| **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 #:** |  |  |
|  |  |  |  |

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.

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