CLIENT LIABILITY DETERMINATION FORM

(Please refer to Section 7.08 of the DDAP Fiscal Manual for completion of the form.)

☐ Initial
☐ Re-determination

Date: _____

Client Name	County of Residence	Client ID #

PART I: INSURANCE

Does the client have insurance (private and/or public) coverage? Yes ☐ No ☐

If insurance has been denied, indicate the reason for denial.

Denied:

Insurance Company	Name of Insured	Group #	ID #

If the SCA is not reimbursing for the cost of service or the service is exempt, DDAP does not require completion of the form.

PART II: FAMILY (As determined by Federal Law/Federal Tax Return)

Name of Dependents	Relationship
	Self

Total # of Dependents (including Self): ____

PART III: MONTHLY GROSS INCOME

List all income from full- and part-time employment as well as other types of income, as applicable, including that of Self, Spouse and Parents (see Section 7.03 of the DDAP Fiscal Manual for income to be included). See description of types of income below.

Family Member	Employers
Self	
Spouse	
Parent I (if applicable)	
Parent II (if applicable)	

Types of Income	Self	Spouse	Parent I	Parent II	Totals
Earned Income (i.e., wages, salaries, tips, bonuses, etc.)					$0
Interest Income					$0
Dividends					$0
Benefits (i.e., unemployment, social security, public assistance, pensions, etc.)					$0
Alimony					$0
Other Taxable Income					$0
Totals	$0	$0	$0	$0	$0

Total Monthly Gross Income: $0

DESCRIPTION OF TYPES OF INCOME

Earned Income:	Wages, salaries, fees, commissions, tips, bonuses, net business income and other earned income subject to Federal income taxation.
Interest Income:	Interest income including, but not limited to, interest received from accounts with banks, savings and loan associations, money market funds, credit unions or bonds.
Dividends:	Dividends received from corporate stock holdings or cash dividends from life insurance policies.
Benefits:	Taxable benefits, including but not limited to unemployment compensation, Social Security payments and pensions. Benefits are counted as income only if the benefit is paid on behalf of the client. Food stamps are not counted as income.
Alimony:	Includes alimony received or spousal support received prior to divorce. Does not include child support.
Other taxable income:	Includes all other income subject to Federal income taxation, e.g., rental income, lottery winnings, net capital gains, etc.

PART IV: CLIENT LIABILITY

Total # of dependents (listed in Part II): 0

Total Monthly Gross Income (listed in Part III): $0

		CLIENT LIABILITY DUE							
Service	Applicable Liability Percentage*	Individual Hour	Group Hour	Group Session	Day	Week	Urinalysis	Dosing	Other (Specify)
Outpatient					xxxxxxxx	xxxxxxxx		xxxxxxxx	
IOP						xxxxxxxx		xxxxxxxx	
Partial						xxxxxxxx		xxxxxxxx	
Halfway House	xxxxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx		xxxxxxxx	xxxxxxxx	xxxxxxxx	
Residential	xxxxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx		xxxxxxxx	xxxxxxxx	xxxxxxxx	
Methadone									
Other (specify)									

*Minimum co-pays may apply

AGREEMENT AND UNDERSTANDING:

I certify that the information concerning my dependents, insurance and income is true and complete to the best of my knowledge. I understand that I am responsible for paying the above fees on the same day of service. I understand that I am to notify this agency if there are any significant changes in my monthly income or family size within 30 days of such change. I understand that if these fees represent a financial burden, a staff person and I may fill out a REQUEST FOR LIABILITY REDUCTION OR ELIMINATION form.

A copy of this form has been offered to me and I have _____ accepted _____rejected it.

Client Signature _____ Date _____

Staff Signature/Witness _____ Date _____

SCA Signature (as applicable) _____ Date _____

Note: Client Liability determined on this day shall be valid for a period of no more than 12 months, with a re-determination to occur at the end of the 12-month period.