Clear Form

Special Medical Needs Assistance Intake Form

Safety Net Program • Special Medical Needs Assistance
Aging, Disability, and Veterans Services Division

Multnomah County

Date | Referral Source | Name | Phone | Agency - Select | Other

Applicant Information

Name • Last | First | MI | Social Security #

DOB | Phone | Medicaid # | Gender ☐ Female ☐ Male ☐ Transgender

Apt Bldg Name | Address | City | State | Zip

Total number in household

of children

*Please specify all other household members not already listed (name/DOB/relationship to applicant)

☐ Single individual ☐ Couple ☐ Parent(s) with child(ren)

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Reported

Race

(check all that apply) ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Black or African American ☐ Other (specify) ☐ Not reported or Unknown

Veteran Status

Has applicant ever served in the military? ☐ YES ☐ NO

Is applicant the surviving spouse of someone who served in the military? ☐ YES ☐ NO

Is applicant in receipt of any veterans' benefits? ☐ YES ☐ NO

Monthly Income

Applicant	$
Source	
Other household member	$
Source	
Total household income	$ 0.00

Does applicant receive Supplemental Nutrition Assistance Program benefits (SNAP)? ☐ YES ☐ NO

Other resources & assets $

Combined value of any financial asset including retirement accounts, saving bonds, mutual funds, stocks, certificates of deposit and life insurance for client & spouse

Does applicant have rep payee? ☐ YES ☐ NO

Monthly Expenses

Rent or Mortgage	$
Essential utilities (gas, electric, water, etc.)	$
Telephone	$
Cable TV	$
Car payments	$
Car insurance	$
Car fuel/oil	$
Bus fare	$
Credit card payments	$
Out-of-pocket medical costs	$
Food	$
Other (specify)	$
Total monthly expenses	$ 0.00
Income minus expenses	$ 0.00

Please complete the following questions

1. **What is the applicant requesting?** (include item #, if applicable, and any other description)

2. **Cost/Amount Requested** (include quote from vendor) $

3. **Circumstances of Request**

4. **How will assistance address applicant's health/independence?**
Please describe how assistance will address the circumstances identified above. Include relevant information regarding the client's medical condition, previous requests for assistance, APS or MDT involvement, and service priority level if client is receiving in-home care

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Continued

Date		**Applicant name**	

5. **Other resources explored**

6. **Additional comments**

Vendor Payment Information (required)

Item name and/or number	
Company name	
Contact person	
Phone number	
FAX number	
Email address	

Additional payment information

Please include any accompanying documentation
(For example, vendor quote/letter of medical need from health care professional)

FOR CENTRAL ADVSD USE ONLY

ADVSD Authorization	Date

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I certify the foregoing statements are true and correct to the best of my knowledge. I understand that the above information may be released to agencies in the Aging, Disability & Veterans Services (ADVSD) network, as needed, in determining eligibility and/or providing services to my family and me. I also authorize Multnomah County ADVSD to speak to my payee about financial-related information, and my health care providers or insurance carrier about health-related information. The information provided here is subject to verification by authorized local or federal officials.

We, the undersigned, have participated in the development of this Special Medical Needs Case Plan.

I hereby authorize the release of the above information for the purpose of evaluating my request for assistance and for further follow-up research.

Applicant Signature	Date

Interviewer Signature	Date	Agency and/or Phone

☐ Check here for electronic signature

Please email this completed PDF (3 pages) to

ADVSD Special Medical Needs Assistance Program

EMAIL (secure) • advsd.safetynet@multco.us