MTF Financial Verification Form

AGENCY: _____ FAX #: _____
PRACTITIONER: _____ PHONE: _____

CLIENT NAME: _____ CLIENT DOB: _____
CLIENT ADDRESS: _____ CITY, STATE: _____
ZIP CODE: _____
PHONE: _____ □ MALE □FEMALE

INVESTIGATION OF PAYMENT SOURCES

	Source	Source Available (Circle one)		Date Verified (MM/DD/YY)
A.	Medicaid / Oregon Health Plan	**Y**	**N**	_____/_____/_____ Date applied: _____/_____/_____
B.	Medicaid spend down programs (P2 medically needy program)	**Y**	**N**	_____/_____/_____
C.	Medicare	**Y**	**N**	_____/_____/_____
D.	Private Insurance	**Y**	**N**	_____/_____/_____
E.	Other Specify: _____	**Y**	**N**	_____/_____/_____
F.	Client Resources (Client is able to pay all or part of the amount due after 3rd party payment)	**Y**	**N**	_____/_____/_____

G. Client's/Family's gross income per month: $_____

H. Number of Family Members in Household (including Client): _____
(If household is greater than one, income identified above must be family's gross income)

I. Client's liquid assets (include savings): $_____

J. Medical hardship expenses (monthly): $_____

CERTIFICATION BY AUTHORIZED CONTRACTOR / BILLING AGENCY

I hereby acknowledge that the above-named person has asked about the above-listed sources of payment, and has verified that this client has applied for Medicaid (OHP) and/or other benefit/entitlement programs for which s/he may be eligible. To the best of my knowledge, no payment source is available for services rendered on or between the dates listed above. This contractor will confirm this client's eligibility for MTF funding. If other funding sources become available for this client, contractor will notify Verity and will bill those sources. All required documents are on file and subject to audit by Multnomah County Department of County Human Services.

_____ ____/____/____
Authorized representative signature (Required) Date

_____
Printed name