Multnomah County

Eligibility for Indigent Services Funding Form - Multnomah County Addiction Services

Multnomah County Behavioral Health Division requires providers to document information regarding eligibility for indigent SUD services. Eligibility is determined at intake and minimally every 6-months. Providers should continually conduct ad hoc eligibility recertification when clients undergo significant life changes that may impact their eligibility (e.g.: gain new employment, changes to residency, obtain new insurance, etc.). Providers may use this form or their own Agency form (if it includes all necessary information). This documentation should be maintained in the client's chart and be made available in case of an audit.

Legal First/Last Name:	Date of Birth:
Address/Location:	
*If homeless note where majority of nights spe	nt
Multhomah County Resident	
	e only for Child Room & Board, not covered for any other service)
Initial Insurance status:	
□ Currently applying for OHP/Provider will a	assist in applying for OHP
□ Has Medicare as primary insurance	
Unable to obtain Insurance	
Underinsured Check all that apply:	
☐ High Deductible (Cx unable to affe	ord)
□ No in network providers	□ Other:
Income Source:	Monthly Amount:
SSI	
SSDI	
Retirement/Pension	
General Assistance (e.g. TANF)	
Employment (client)	
Employment (spouse)	
Court Judgment (Child support, Spor	usal support, etc.)
Other (e.g. Trust Fund, Investments,	etc.)
Total Income	
Number in family	
Meets Current Year Guidelines for 2	00% Federal Poverty Level (FPL) 🛛 Yes 🗌 No
Agency Name:	Phone #:
By signing below, the agency attests to verifi	ation of the client's eligibility for Multnomah Other:
Staff signature St	aff name (Please print) Date
I certify that the information provided above	is accurate to the best of my knowledge. I understand that any false information
	rvices. I agree to notify my provider if there is a significant change in my
financial circumstances, if I become enrolled o	on the Oregon Health Plan or other insurance, or I am no longer a Multnomah
County resident. If client unavailable for signo	ature, please note reason instead.
Client Signature	ate
Reason Client Unavailable:	
Revised 3/30/2022	Effective March 2022

<u>Recertification for Indigent Services Funding Form – Multnomah County Addiction Services</u>

Legal First/Last Name: ______

Eligibility recertification is due at each 6 months interval

Recertification Date	Staff Name and Signature Verifying Eligibility	Income (sources include SSI, SSDI, TANF, Employment, Child/Spousal Support, etc.)	Insurance Status	County of Residence
6 Months Date:	Staff Name: Signature:	 ☐ Meets Current Year 200% Fed Poverty Lvl <u>AND</u> □ Income Unchanged <u>OR</u> Complete: Current Income Sources: 	 Has Medicare as primary insurance Unable to obtain Insurance. Underinsured High Deductible (Client unable to afford) Benefit exceeded (\$ amt/session limit exceeded) No in network providers Other: 	Multnomah County Resident
		Current Total Monthly Income: Current Household size:		
6 Months Date:	Staff Name: Signature:	☐ Meets Current Year 200% Fed Poverty Lvl <u>AND</u> ☐ Income Unchanged <u>OR</u> Complete: Current Income Sources:	 Has Medicare as primary insurance Unable to obtain Insurance. Underinsured High Deductible (Client unable to afford) Benefit exceeded (\$ amt/session limit exceeded) No in network providers Other: 	Multnomah County Resident
		Current Total Monthly Income: Current Household size:		

Legal First/Last Name: ______

Recertification Date	Staff Name and Signature Verifying Eligibility	Income (sources include SSI, SSDI, TANF, Employment, Child/Spousal Support, etc.)	Insurance Status	County of Residence
6 Months Date:		 ☐ Meets Current Year 200% Fed Poverty Lvl <u>AND</u> ☐ Income Unchanged <u>OR</u> Complete: Current Income Sources: 	 Has Medicare as primary insurance Unable to obtain Insurance. Underinsured High Deductible (Client unable to afford) Benefit exceeded (\$ amt/session limit exceeded) No in network providers Other: 	Multnomah County Resident
		Current Total Monthly Income: Current Household size:		
6 Months Date:	Staff Name: Signature:	 ☐ Meets Current Year 200% Fed Poverty Lvl <u>AND</u> ☐ Income Unchanged <u>OR</u> Complete: Current Income Sources: 	 Has Medicare as primary insurance Unable to obtain Insurance. Underinsured High Deductible (Client unable to afford) Benefit exceeded (\$ amt/session limit exceeded) No in network providers Other: 	Multnomah County Resident
		Current Total Monthly Income: Current Household size:		