Multnomah County

Aging, Disability & Veterans Services Division
Oregon Project Independence (OPI)

District Center: ☐ EC ☐ ME ☐ NE ☐ FH ☐ PT

Enhancing Equity: ☐ UL ☐ IR ☐ GG ☐ AS

Date: _____ Prime number:_____

Client name:_____ _____
(last name) (first name)

This invoice is for the **OPI co-pay** for consumers receiving **in-home services from a Home Care Worker (HCW)** employed by the consumer.

_____hours of service at your hourly pay-in fee of _____ for the period of _____ through_____=

AMOUNT DUE: _____

Please make payment within 30 days of receiving this invoice, or services will be cancelled!

Please make checks payable to **ADVSD** (Aging, Disability and Veteran Services.) **Do not send cash.**

Mail this form with check to:

MULTNOMAH COUNTY, DCHS AGING & DISABLILITES SERVICE
PO Box 40488
Portland OR 97240-0488

Invoices are mailed after services have been delivered. Amount charged based on services received.

Please contact your case manager with any questions:
Case manager:_____ Phone #:_____