Client Enrollment Form

MHASD Culturally Specific Program

Provider Name:_____

Provider Address:_____

_____

Multnomah County
Mental Health & Addiction Services
Attn: Business Services
421 SW Oak Street, Suite 520
Portland, OR 97204
Fax: 503-988-5870

Date:
Invoice #:
Invoice Month/Year:
Total Amount Due:

Client Name	DOB	Gender	Client ID	Effective Date	Race/ Ethnicity
Please direct questions about this roster to:			Total # Clients:		
Contact Name:			Total Amt. Due:		
Contact Phone #:					

Race/Ethnicity:

01-White (Non-Hispanic)
02-Black (Non-Hispanic)
03-Native American
04-Alaskan Native
05-Asian
06-Hispanic (Mexican)
07-Hispanic (Puerto Rican)
08-Hispanic (Cuban)
09-Other Hispanic
10-Southeast Asian
11-Other Race
12-Native Hawaiian/Other Pacific Islander

I hereby certify that I am authorized to prepare this roster. I further certify that the individuals listed above meet the financial criteria and reside in Multnomah County. The information provided on this invoice is true and accurate to the best of my knowledge.

Print Name_____Signature_____Date_____