Multnomah Treatment Fund (MTF) - Client Insurance Verification Documentation

Contracted providers will use this form to document that clients meet the insurance MTF criteria. Save a copy of this form/information in the client records. Multnomah County will do periodic audits to ensure that provider completed this form and that clients meet insurance requirement for MTF.

Provider Information:

Date Filled out (dd/mm/yyyy): _____Person Completing :_____ Provider Agency: Pick one Provider Site Name:_____

Client Information and Financial Resources:

First Name: _____ Last Name:_____ Affirmed Name: _____
Date of Birth (dd/mm/yyyy)_____
Income below 200% of Federal Poverty line? ☐ Yes ☐ No

Investigation of Insurance Payment Sources

Insurance Source, if applicable:		Date Applied
Medicaid/Oregon Health Plan		
Medicare		
Private insurance, please specify:		
Other, please specify:		
☐ Advised to Reapply on Later date ☐ Ineligible/Denial ☐ Referred to Benefits Eligibility Specialist Team (BEST)		

If applicable Service provider initiated application for health insurance benefits for client?
☐ Yes ☐ No
Application completed by _____
Was client present and assisted ☐ Yes ☐ No

Certification by Authorized Contractor/Billing Agency

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

Electronic Signature: _____ Date:_____