



Washington County Health and Human Services

Income Verification for General Fund Services

12/1/09

Name: _____	Date: _____
GF#: _____	SSN#: _____
Agency: _____	DOB: _____
Primary Clinician: _____	

Washington County Resident
 Household income is less than 200% of FPL for Adult Services, 250% for Children's Services
 No insurance or is significantly underinsured (i.e. insurance benefit exhausted or inadequate to provide the basic services needed to be successfully maintained in the community)
 Cannot be adequately served by other community resources (i.e. free or low cost counseling or healthcare, primary care clinics, substance abuse treatment programs, etc.)

Income Source	Monthly Amount
SSI	
SSDI	
General Assistance	
Employment (client or parent if for a child)	
Employment (spouse)	
Trust Fund	
Food Stamps	
Court Judgement (child support, spousal support, etc.)	
Other Resources	
Total Income:	
Number in Family:	

Assets:

Savings/Available Cash	Total dollar amount: \$ _____
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I have applied for Oregon Health Plan (for client) YES ____ / NO ____

If not, it is because: _____

I certify that the information provided above is accurate to the best of my knowledge. I understand that any false information may result in immediate disqualification of general fund services. I agree to notify my provider if there is a significant change in my financial circumstances. I agree to allow disclosure of my Social Security Number to Washington County Health and Humans Services and their third party administrator, PHTech. This information will be used for eligibility determination.

Client: _____ Date: _____

Clinician: _____ Date: _____

Please attach this form to the Authorization Request form and fax to Washington County Mental Health at 503-846-4560. This form must be completed annually or whenever general fund services are being requested.