FINANCIAL INFORMATION FORM

Please P R I N T

Client Name: ____

Home Phone: ___________________________ Work Phone: ___________________________

Mailing Address: ____

Billing Address (if different): ____

If Minor, Parent or Guardian: ____

Name and Address: ____

Person to Contact in Case of Emergency: ____

HOUSEHOLD INFORMATION (tax filing unit)

Please list the taxpayer, spouse, and all claimed dependents; starting with you:

Name	Relationship to You	Date of Birth	Gender (M or F)	Social Security Number	Marital Status S – Single M Married D – Divorced W - Widowed	U.S. Citizen Y or N	Montana Resident Y or N
	SELF						

INCOME

Income Received from Employment

List all household members that are part of the tax filing unit and are expected to file a tax return. Dependents with earned income more than $6,300 must file a tax return. Include full-time, part-time, and seasonal employment, temporary or spot jobs, tips, and commissions. For self-employment and farm income, state average monthly income.

Name of household member	Name of employer	Start date	Average hours worked per week	Pay/wages per hour	If tip income is earned, amount of tips per week	Is this job seasonal? If yes, number of weeks or months worked per year.	Total Annual Gross Income

Income Received from Sources Other than Employment or Self-Employment:

List all unearned income received by all household members that are part of the tax filing unit and expected to file a tax return. Dependents with unearned income more than $1,050 must file a tax return. Unearned income includes; but is not limited to, Social Security Disability Income, Rental income, Unemployment Benefits, Veteran's retirement, Pensions, Alimony received, Lease or Rental Income, Dividends, Interest.

Name of household member	Type of income	Source of income	How often is income received? (weekly, bi- weekly, monthly, semi- monthly, annually)	Amount received

HEALTH INSURANCE:

Policyholder's Name and SSN	Insurance Company	Policy Number	Group Number	Who in household is covered?

Modified Adjusted Gross Income (MAGI)

Includes:
Wages, Salary, Tips, Interest, Self-employment income, Unemployment compensation, SSDI, Dividends, Annuity Payments, Capital gains, Alimony received, Rental and Lease income, Military retirement, Pensions, VISTA/AmeriCorps, other income

Excludes:
Child support received, Gifts and Inheritance, Worker's Compensation, Veteran's benefits (VA), Military allotments, Scholarships or grants used for educational purposes, some Native American income, SSI benefits, welfare and public assistance payments, foster care payments, Adoption subsidies.

Deducts:
Alimony paid, Pre-tax contributions (401K, flex plans, HSA, health insurance), Medical expenses (above 10% of MAGI), Tuition and Fees, Student Loan interest, moving expenses.

The family (tax filing unit) consists of the taxpayer (includes married filing jointly), spouse, and all claimed dependents. The MAGI for the client would be the combined income for all members of that family (tax filing unit) that are required to file tax returns.

Note: For further clarification, please refer to the Chemical Dependency Provider Manual.

RIGHTS AND RESPONSIBILITIES

I understand I must report any changes in the information provided on this application to the Department of Public Health and Human Services (DPHHS) Addictive and Mental Disorders Division. Late reporting may cause incorrect benefits. Changes must be reported within 10 days of my knowledge of the event.

I must provide proof that my children are eligible for benefits. I may receive help in gathering documents or contacting individual or agencies by calling (insert program phone number here).

I know the information I have given may be reviewed and verified by a representative of the State of Montana or (insert name of program). I also understand that I must cooperate fully with state, federal, and (insert name of program) staff if my case is reviewed. By signing this application, I have given my permission for the State of Montana and (insert name of program) to obtain verification and information necessary to determine my eligibility or my children's eligibility. I understand that my permission includes the use of my social security number and/or my children's social security number to obtain the information.

I know the information I have given is confidential. I agree that medical information about me or my children can be released only if needed to administer, including billing for, the services received. Information will be forwarded to other agencies or organizations only if I have given my permission on this form.

If my children are enrolled in Medicaid, their health insurance or other third-party payments are automatically assigned by law to the State of Montana. Montana law requires that any money received by my household for medical expenses that are previously paid by Medicaid must be reimbursed to the State.

I understand that I may request a Fair Hearing if I disagree with any action taken as the application for children's health care is processed, and that the request for Fair Hearing must be in writing.

I know this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

I certify that the information I have provided is true to the best of my knowledge and I give permission for the State of Montana and (insert name of provider here) to make necessary contacts to check my statements. I understand that my permission includes use of my social security number and/or my children's social security number to obtain the information. I agree that medical information about me or my children can be released only if needed to administer, including billing for, the services received.

Signature of Client or Guardian: ______________________________ Date: ____________________

Signature of Witness: ______________________________ Date: ____________________