rosecrance

Mental Health Income Verification/Consumer Choice to bill DHS

Date _____ **I.D. number** _____

Client name _____ **Date of birth** _____

Family Size _____ **Consumer income** _____ **Family income**_____
annual/monthly annual/monthly
(Please attach copies of proof income.)

Medicaid (Yes or No) _____ **RIN** _____

Other insurance (Yes or No) _____ **Type** _____

DOCUMENTATION OF FAMILY SIZE AND INCOME (Consumer must initial below.)

_____ I certify that the information concerning my family size and income is current and accurate. I agree to notify Rosecrance of any changes in this information.

DOCUMENTATION OF CONSUMER CHOICE TO RECEIVE DHS-FUNDED SERVICES

If you meet the income eligibility criteria, the Department of Human Services (DHS) may pay for some or all of the costs of your mental health services. If DHS is to pay for these services, we must report certain personal information to the Department. If you do not want us to report this information, you may decline to be a recipient of DHS funding. If you do not decline, we will report all of the following information to the Department of Human Services:

- Your name (first, middle and last)
- Your Social Security number
- Your birth date and gender
- Your county of residence
- Your household income and size
- All mental health services to be paid

_____ **I CHOOSE** to have Rosecrance bill DHS for my services, and I understand the above information will be reported to the Illinois Department of Human Services.

_____ **I DO NOT** choose to have Rosecrance bill DHS for my services, and I understand the above information will not be reported to the Illinois Department of Human Services. I will be responsible for paying for all the services I receive according to Rosecrance policy.

_____ _____
Signature of Consumer or Parent/Guardian Date

_____ _____
Signature of Center Staff Date

(See reverse for zero income or no documentation.)

9-1-11 Income Verification — Legal Section

Office use only — Data Entry:
Entry Date:
By:

rosecrance

Mental Health Income Verification/
Consumer Choice to bill DHS (cont.)

Guardian Name _____ **Client Name and I.D. #**_____

I am asking for Mental Health Services from Rosecrance but have no means of formally documenting my household income at this time.

In the past month, I have **received** income from: **Monthly amount** $ _____

☐ Wages, tips, commissions

☐ Unemployment compensation

☐ Severance payments

☐ Social Security, Social Security Disability, Veteran's Benefits or other Federal benefits

☐ Private pension, retirement plan or investment income

☐ Temporary Aid to Needy Families, local General Assistance or other State benefits

☐ Child support or alimony

☐ **I DO NOT** have a current checking account.

☐ **I DO NOT** have a current savings account.

☐ I have no current income, but I am currently living on my own and paying for my expenses by

_____.

☐ I am currently living with _____, who provides me with food, shelter and basic necessities.

☐ I pay monthly rent in the amount of $ _____ that comes from _____.

☐ I do not pay rent.

☐ I have a cell phone that I pay $ _____ for each month. That money is from _____.

☐ I have a checking account and have provided a copy of my most recent bank statement showing my balance is $ _____.

☐ I cannot provide a copy of my most recent bank statement because _____

_____.

☐ I have a savings account and have provided a copy of my most recent bank statement showing my balance is $ _____.

☐ I cannot provide a copy of my most recent savings account statement because _____

_____.

Guardian signature _____ Date _____

Staff name _____ Signature _____ Date _____

Staff notes _____

_____