Four County ADAMhs Board Self-Declared Zero Income Form

Date: _____

Provider Agency: Maumee Valley Guidance Center

Client Name: _____

Address: _____

City/State/Zip: _____

County: _____

Date of Medicaid Application: _____

Date of Medicaid Denial: _____

I state that at the present time, that I have no income sources and am not employed.

If and when I become employed or secure any income source, I agree to report any changes in my finances immediately to the Agency where I am receiving my mental health or AOD services. I acknowledge that by signing this form, I authorize the Four County ADAMhs Board or its designate representatives to have access to public assistance, social security, employment or other records needed to verify the statements that I have made. I further acknowledge that by signing this form, I agree to apply for Medicaid.

_____ _____

Client/Guardian Signature Date

_____ _____

Staff Member Signature Date

This form is required to be updated (6) months after the signature date, or when the agency learns of changes.