

Health-Related Income/Budget Worksheet

Last updated: January 2026



Thank you for submitting a health-related services request. In some cases, our team needs more information to determine your sustainability plan and what resources you have. Please fill out the below form to provide more information so we can determine how best to support you.

Member information

Member name: _____ Date of birth: _____

Member ID: _____ Date: _____

Current address/residence: _____

Number of months/years at current residence: _____

Use the table below to calculate the number in your household

| | |
|--|--|
| Yourself | |
| Your legal spouse | |
| Your live-in partner (if you have a child under age 19 with this person) | |
| Children (under age 19) who live with you | |
| Anyone else that you include on your federal income tax return, even if they don't live with you | |
| If you are under 19, any parents, step-parents and brothers or sisters (also under age 19) who live with you | |
| Anyone who is pregnant in your household | |
| Any expected babies of pregnant people in your household | |
| Total number in household: | |

Current housing situation

- Own my home
- Houseless
- Rent (only one household living at this address)
- Share rent (with roommates or with another household) Your portion is: _____

Income

| Income source | Monthly amount Adult #1 | Monthly amount Adult #2 | Monthly amount Adult #3 | Monthly amount Adult #4 | Monthly amount Adult #5 |
|-----------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| AFDC (TANF) | | | | | |
| Employment PT/FT | | | | | |
| VA benefits | | | | | |
| SSI/SSDI | | | | | |
| Unemployment | | | | | |
| State disability | | | | | |
| Foster care income | | | | | |
| Disabled family member | | | | | |
| Child support/alimony | | | | | |
| Pension/retirement | | | | | |
| Business income | | | | | |
| Interest or dividend income | | | | | |
| Other income | | | | | |
| Total: | | | | | |

Do **not** count these as income:

- Income of children under 18
- Inheritance and insurance income
- Student financial aid
- Medical expense reimbursement
- Income of live in aide
- Armed forces hostile fire pay
- SNAP benefits

Expenses for the next three months

Current month's expenses

| | | | | | |
|---------------|----|--|--------------------|----|--|
| Rent/mortgage | \$ | | Car payment | \$ | |
| Gas | \$ | | Car insurance | \$ | |
| Electric | \$ | | Gasoline | \$ | |
| Water | \$ | | Household supplies | \$ | |
| Trash | \$ | | Food | \$ | |
| Phone | \$ | | Childcare | \$ | |

Next month's expenses

| | | | | | |
|---------------|----|--|--------------------|----|--|
| Rent/mortgage | \$ | | Car payment | \$ | |
| Gas | \$ | | Car insurance | \$ | |
| Electric | \$ | | Gasoline | \$ | |
| Water | \$ | | Household supplies | \$ | |
| Trash | \$ | | Food | \$ | |
| Phone | \$ | | Childcare | \$ | |

Third month's expenses

| | | | | | |
|---------------|----|--|--------------------|----|--|
| Rent/mortgage | \$ | | Car payment | \$ | |
| Gas | \$ | | Car insurance | \$ | |
| Electric | \$ | | Gasoline | \$ | |
| Water | \$ | | Household supplies | \$ | |
| Trash | \$ | | Food | \$ | |
| Phone | \$ | | Childcare | \$ | |

Total monthly income _____ Total monthly expenses: _____

Did you report no income? Yes No

If yes, do you have a case manager that we can call to validate your income?

Case worker name: _____

Agency: _____

Email address: _____

Phone number: _____

- I give permission for CareOregon to call my case manager to validate my income.
- I do not have a case manager/case worker who can validate my income. I attest that the income listed on this worksheet is true and complete to the best of my knowledge.

Signature: _____

Current financial spending

Please tell us more about your current money situation.
What caused you to miss paying your bills?

Plan to increase income and reduce expenses

| Action | | Target date |
|--------|--|-------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Submission of forms

You can fill out this form yourself, or with the help of a parent, a caregiver, or a guardian/support/trusted friend, or a staff member from an organization or clinic.

Fax completed forms to:

503-416-1376

ATTN: HRS

Any documents related to your request should be sent in advance. Here are two ways to submit:

Submitting via the member portal

The quickest way to submit documents or check the status of your request is through our member portal. It is a secure messaging platform you can access through our website via a desktop computer. You can sign in if you have an account, or follow the on-screen instructions to sign up.

Please note: You must be over 18 to sign up for an account.

To access the portal, go to careoregon.org/memberportal

Once logged in, upload your documents by doing the following:

1. Go to the message center and click "new message"
2. Click "add recipients" and select "Health Related Services Requests"
3. Add HRSN in the subject line and attach the file(s) to the message using the attach file feature
4. Add any other context and click "send"

Submitting via email

If you cannot access the portal, you can send your documents to us via email at

HRSNCX@careoregon.org

If you have questions or would like help filling out the request form(s), call CareOregon Customer Service at 971-236-2998.

You can get this document in other languages, large print, braille or a format you prefer. **You have the right to an interpreter. You can get help from a certified or qualified health care interpreter.** This help is free. Call 800-224-4840, TTY 711, or tell your provider. We accept relay calls.