

## CLAIM FORM INSTRUCTIONS

You must complete a Claim Form in order to receive payment from the Settlement Fund. Please follow these instructions.

**All claims must be *received* by the Claims Administrator no later than April 20, 2016.  
Any claims received after this date will not be eligible for payment.**

### A. FRONT AND BACK OF CLAIM FORM MUST BE COMPLETED

**Recipient Claimants:** Please identify: (1) the dates (month/year) in which you paid for additional personal care services, (2) the identity of the provider who rendered personal care services in excess of that authorized by DSHS, (3) the provider's address and telephone number (if available), and (4) the amount you paid for the services. If you do not know the dates, you may wish to contact your care provider.

**Provider Claimants:** Please identify the date (month/year) during which you worked in excess of DSHS-authorized hours for the child Medicaid recipient with whom you lived and to whom you were authorized to provide care. For each month of unpaid caregiving, you must provide on the Claim Form: (1) the dates of unpaid caregiving (month/year), (2) the name of the child Medicaid recipient to whom you provided unpaid caregiving, (3) the shared address for both you and the child Medicaid recipient at the time of service, and (4) an attestation (statement) that you were not paid for the additional work.

**All Claimants:** You must sign the *CERTIFICATION* on the back of the form demonstrating that the information you have provided is true and correct and authorizing the Claims Administrator and DSHS to investigate your claim.

### B. DOCUMENTATION

**Recipient Claimants** must also send in evidence of the service dates (month/year) and payment:

1. Service dates can be evidenced by provider notes, an appointment schedule/log, invoices seeking payment that include dates of service, or other evidence of similar reliability.
2. Proof of payment may consist of cancelled checks, credit card account statements, provider ledgers, invoices stamped "paid" or showing amounts due, checking account statements, signed letters from the provider or provider's employer documenting the amount paid (so long as the letter connects payments with service dates), or other evidence of similar reliability.

### C. ALL OF YOUR CLAIMS MUST BE SUBMITTED IN ONE MAILING

You may obtain additional copies of the Claim Form or make copies of it yourself. Documents that you submit will not be returned, so please do not send originals.

### D. MAIL YOUR CLAIM FORM

Your Claim Form, with documentation if required, must be received by **April 20, 2016**. It should be mailed to:

*M.T.E., et al. v. DSHS* Claims Processing  
P.O. Box 3266  
Portland, OR 97208-3266

You may not submit Claim Forms by telephone, fax, email, or other means. If you want verification that your Claim Form was received, then you must mail your Claim Form using registered or certified mail.

### E. INVESTIGATION

The Claims Administrator and/or DSHS may independently confirm any claim. By submitting a Claim Form, you agree that such an investigation may be made. The failure to cooperate may be grounds for denial.

### F. PAYMENT OF CLAIMS

The Claims Administrator will process all claims and determine whether you may be paid out of the Settlement Funds. Payment is contingent upon final Court approval of the proposed Settlement Agreement. This process may take several months. If your claim is approved by the Claims Administrator and authorized by the Court, you will be mailed a check for the approved amount of the claim. If your claim is denied, in whole or in part, the Claims Administrator will provide a letter of explanation. You will be given an opportunity to correct any problems. If you disagree with the Claims Administrator's determination, then you may follow the steps set forth in the denial letter to appeal.



M.T.E., et al. v. DSHS Settlement Fund Claim Form

If you have questions about how to complete this Claim Form, your claims, or how to appeal a denial, write to Richard E. Spoonemore or Eleanor Hamburger, Class Counsel, SIRIANNI YOUTZ SPOONEMORE HAMBURGER, 999 Third Avenue, Suite 3650, Seattle, WA 98104; call (206) 838-3210; or email ehamburger@syllaw.com or rspoonemore@syllaw.com.

PROVIDER CLAIM FORM

Name of Person who received services

First Name

MI

Last Name

Grid for First Name

Grid for MI

Grid for Last Name

Date of Birth of the person who received services

Dates of Service

Grid for Date of Birth (MM-DD-YYYY)

Grid for Dates of Service (MM/YY-MM/YY)

MM DD YYYY

MM YY MM YY

Shared Address:

Shared Address text box

I hereby certify that I worked in excess of authorized DSHS hours and was not paid. Yes No

Name of Person who received services

First Name

MI

Last Name

Grid for First Name

Grid for MI

Grid for Last Name

Date of Birth of the person who received services

Dates of Service

Grid for Date of Birth (MM-DD-YYYY)

Grid for Dates of Service (MM/YY-MM/YY)

MM DD YYYY

MM YY MM YY

Shared Address:

Shared Address text box

I hereby certify that I worked in excess of authorized DSHS hours and was not paid. Yes No

Name of Person who received services

First Name

MI

Last Name

Grid for First Name

Grid for MI

Grid for Last Name

Date of Birth of the person who received services

Dates of Service

Grid for Date of Birth (MM-DD-YYYY)

Grid for Dates of Service (MM/YY-MM/YY)

MM DD YYYY

MM YY MM YY

Shared Address:

Shared Address text box

I hereby certify that I worked in excess of authorized DSHS hours and was not paid. Yes No

Name of Person who received services

First Name

MI

Last Name

Grid for First Name

Grid for MI

Grid for Last Name

Date of Birth of the person who received services

Dates of Service

Grid for Date of Birth (MM-DD-YYYY)

Grid for Dates of Service (MM/YY-MM/YY)

MM DD YYYY

MM YY MM YY

Shared Address:

Shared Address text box

I hereby certify that I worked in excess of authorized DSHS hours and was not paid. Yes No

NOTE: If you need additional pages for more claims, you may either make a copy of this blank Claim Form or obtain additional forms from www.SYLLAW.com/MTESettlement. You must also fill out the back side of this form to be eligible for reimbursement.

M.T.E., et al. v. DSHS  
PROVIDER CERTIFICATION OF WORK

I certify that I was a qualified Individual Provider of Medicaid-funded personal care services living with and providing services to a recipient of Medicaid-funded personal care services who was, at the time of service, under the age of 18 years, between July 1, 2005 and November 30, 2011 (the "Class Period").

I certify that I provided personal care services in excess of the amount authorized by DSHS during the identified months in the Class Period.

I further certify that I was not paid for the personal care services performed in excess of the amount authorized by DSHS during the identified months.

I certify that the information provided in this Claim Form is true and correct. I understand that the payment of my claim may involve federally funded Medicaid dollars.

I authorize Epiq Systems to obtain any necessary information from the Washington Department of Social and Health Services and/or the Medicaid recipient to whom I provided services who is identified on the attached Claim Form to confirm this certification.

\*\*\*

Signature:

Date:  -  -   
MM DD YYYY

Provider Name

Type or Print Your Name (required):

First Name  MI  Last Name

You **must** include the following information with this Claim Form: (1) the dates when you lived with a child Medicaid recipient and provided personal care services in excess of those authorized by DSHS (month/year), (2) the address at which you lived, and (3) the child Medicaid recipient to whom you provided personal care services. Please see the enclosed "Instructions for Claim Form" material under "Documentation" for a list of the types of documents that must be submitted to establish each element.

Current Address:

Street or P.O. Box

City  State  ZIP Code

Daytime/Evening Telephone Numbers:

day  -  -  eve.  -  -

Please include your DSHS identification number: