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.

<<Mail ID>>

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@sylaw.com or rspoonemore@sylaw.com.

RECIPIENT CLAIM FORM

Dates of Service ☐☐ / ☐☐ – ☐☐ / ☐☐ (MM YY MM YY)

Amount You Paid for the Service $ ☐☐☐☐☐ . ☐☐

I certify that the personal care services I paid for were in excess of those authorized by DSHS for that month/year. ☐ Yes ☐ No

Provider Name, Address, and Phone Number (if available)

Dates of Service ☐☐ / ☐☐ – ☐☐ / ☐☐ (MM YY MM YY)

Amount You Paid for the Service $ ☐☐☐☐☐ . ☐☐

I certify that the personal care services I paid for were in excess of those authorized by DSHS for that month/year. ☐ Yes ☐ No

Provider Name, Address, and Phone Number (if available)

Dates of Service ☐☐ / ☐☐ – ☐☐ / ☐☐ (MM YY MM YY)

Amount You Paid for the Service $ ☐☐☐☐☐ . ☐☐

I certify that the personal care services I paid for were in excess of those authorized by DSHS for that month/year. ☐ Yes ☐ No

Provider Name, Address, and Phone Number (if available)

Dates of Service ☐☐ / ☐☐ – ☐☐ / ☐☐ (MM YY MM YY)

Amount You Paid for the Service $ ☐☐☐☐☐ . ☐☐

I certify that the personal care services I paid for were in excess of those authorized by DSHS for that month/year. ☐ Yes ☐ No

Provider Name, Address, and Phone Number (if available)

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.SYLAW.com/MTESettlement. You must also fill out the back side of this form to be eligible for reimbursement.

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RECIPIENT CERTIFICATION OF PAYMENT(S)

Please attach all documents that show that you received and incurred a debt for the services identified above, such as itemized statements, cancelled checks, credit card statements, receipts, treatment summaries, etc.

DO NOT SEND ORIGINALS AS THEY WILL NOT BE RETURNED TO YOU.

I certify that I or my dependent(s)/ward(s) received Medicaid-funded personal care services while under the age of 18 years, between July 1, 2005 and November 30, 2011.

I certify that I or my dependent(s)/ward(s) received personal care services in excess of the amount authorized by the Department of Social and Health Services (DSHS), for which I paid out-of-pocket, as set forth on the Claim Form on the back of this page and any additional pages.

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 personal care providers identified on the attached Claim Form to confirm this certification.

Signature: _____ Date: __ __ – __ __ – __ __ __ __
MM DD YYYY

***

Type or Print Your Name (required):

First Name _____ MI _____ Last Name _____

Name of Person who received services (required):

First Name _____ MI _____ Last Name _____

Date of Birth of the person who received services (required):

__ __ – __ __ – __ __ __ __
MM DD YYYY

You **must** include the following elements of proof with this Claim Form: (1) proof of uncovered personal care service dates (month/year), (2) identity of the personal care provider(s), and (3) proof of the unreimbursed charges. 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: _____