OHIO DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
APPLICATION FOR FINANCIAL ASSISTANCE

Print AFA

Attempts	1st Name/Date	2nd Name/Date	3rd Name/Date

Hospital	Patient Name	Admission Date	PCS Number

SSN	Date of Birth	Patient's Marital Status	If Divorced when final
		☐ Single ☐ Married ☐ Widower ☐ Separated ☐ Divorced	

Address	City	State	Zip	Phone#

Name of the Patient's Spouse	Spouse's Social Security#	Spouse's Date of Birth	Is Spouse's address different than Patient's?
			☐ Yes ☐ No

Address	City	State	Zip	Phone#

Is the patient a veteran: ☐ Yes ☐ No	If "Yes", Patient's VA Claim Number	Patient's Military Service Serial Number

GUARDIAN

Does the patient have a court appointed guardian? ☐ Yes ☐ No Type of Guardian: ☐ Person ☐ Estate ☐ Both	Guardianship Number	Name of Guardian

Address	City	State	Zip	Phone#

INSURANCE (Hospitalization) ☐ Yes ☐ No - Private Policies, Employer Group and Union Group Health Insurance.

Policy covering patient issued in the name of:	Relationship of the Insured to the patient:	Member ID:	Group Number:	Claim Phone#

SUBSCRIBER INFORMATION:

DOB	SSN	Address (Street, City, State Zip)	Phone#

Name(s) and Address(es) of Insurance Company(ies):

MEDICARE ☐ Yes ☐ No
MEDICAID ☐ Yes ☐ No

Important - Please indicate in applicable space below patient's name and health insurance claim number exactly as indicated on patient's Medicare and Medicaid Card(s)?

Medicare Account Number	Medicare Part A Date of Entitlement	Medicare Part B Date of Entitlement
ID Number on Patient's Medicaid Card	**Medicaid (if applicable) Date of Entitlement**	**Patient's Name (exactly as shown on Medicaid Card)**

DEPENDENTS - Does patient have dependents - ☐ Yes ☐ No List all patient's dependents. If patient has more than three dependents, please attach a separate sheet with the additional information

Name	Custody	Date of Birth	Relationship

ADDITIONAL DEPENDENTS INFORMATION - Check any of the following for whom you may claim a deduction as an additional dependency.

Patient is legally blind or deaf	☐ Yes ☐ No	Spouse is legally blind or deaf	☐ Yes ☐ No
Patient is 65 years of age or older	☐ Yes ☐ No	Spouse is 65 years of age or older	☐ Yes ☐ No

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EMPLOYMENT

Patient's Employment Status ☐ Currently Working ☐ Unemployed If Unemployed, Final Date of Employment _____					
Employer's Name			Employer's Address		
City	State	Zip	Phone#	Patient's Occupation	Patient's Adjusted Gross Income LastYear
Spouse's Employment Status ☐ Currently Working ☐ Unemployed If Unemployed, Final Date of Employment _____					
Spouse Employer's Name			Employer's Address		
City	State	Zip	Phone#	Spouse's Occupation	Spouse's Adjusted Gross Income LastYear

SOURCE OF OTHER INCOME

Does Patient have a Payee? ☐ Yes ☐ No Below, please provide Payee's Name, Address and Telephone Number.

Source	Monthly Amount		
	Patient	Spouse	Total
SS Payee: _____			
SSI Payee: _____			
SSDI Payee: _____			
VA Pension			
Unemployment			
Alimony			
Child Support			
Other _____			
Does the patient or spouse have any other income? ☐ Yes ☐ No If Yes, explain and indicate amount of income below:			
Other _____			
Other _____			

If income = 0, please explain how supported.

_____

BANK ACCOUNT

Does the Patient or Spouse have a banking account? ☐ Yes ☐ No List all of patient's or spouse's bank accounts owned individually, jointly, or in trust.

Name(s) on the account	Bank Name & Address (Street, City, State Zip)	Current Balance	Type of Account

OTHER ASSETS ☐ Yes ☐ No - Stocks, bonds, IRAs - if additional space is needed, please attach information.

Account Number	Name & Address (Street, City, State Zip) where account is held	Current Balance	Type of Account

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REAL ESTATE

Does the Patient or Spouse own real estate? ☐ Yes ☐ No - List below any real estate owned individually or jointly by patient. If additional space is needed, please attach information.

How Titled	Address (Street, City, State Zip)	Primary Residence	Current Market Value	Current Mortgage Balance
		☐ Yes ☐ No		
		☐ Yes ☐ No		

LIABILITIES

Does the Patient or Spouse have any liabilities? ☐ Yes ☐ No - List all of patient's or spouse's liabilities.

Items	Name & Address (Street, City, State Zip) where account is held	Monthly Amount
Mortgage		
Home Insurance		
Other _____		
Other _____		

EXPENSES

Does the Patient or Spouse have any expenses? ☐ Yes ☐ No - List all of patient's or spouse's expenses.

Items	Name & Address (Street, City, State Zip) where account is held	Monthly Amount
Gas		
Electric		
Phone		
Other _____		
Other _____		

LIFE INSURANCE AND/OR PREPAID FUNERAL EXPENSES

Does the patient have life insurance? ☐ Yes ☐ No - If "yes" complete the following:	
Name and Address of Life Insurance Company:	Policy Number
Name and Address of Beneficiary:	Face Value of Insurance:
Does the patient have Prepaid Funeral Expenses? ☐ Yes ☐ No - If "yes" complete the following:	
Name and Address of Prepaid Funeral Home:	Amount Prepaid for Funeral:

Section 5121 of the Ohio Revised Code establishes the liability for the support of patients admitted to a state mental health facility and requires the Department of Mental Health & Addiction Services to investigate the financial resources of all patients and liable relatives. Ohio Revised Code 5121.36 (B) states that in order to be considered, the application for modification or waiver of payment must be submitted to the department no later than **ninety (90) days** after the date the patient is admitted to a hospital.

THE INFORMATION IS CERTIFIED AS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF THIS INFORMATION IS NOT COMPLETE OR ACCURATE, I MAY BE CHARGED THE FULL RATE.

Signature of Patient, Spouse or Legal Guardian completing the form	Date Completed

Patient refused to sign: _____, _____, _____

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Return To: _____

Contact No: _____

_____

_____

_____

Date: _____

_____

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_____