

APPLICATION FOR FINANCIAL ASSISTANCE

OHIO DEPARTMENT OF MENTAL HEALTH
 FISCAL OPERATIONS & REVENUE ADMINISTRATION
 30 E. BROAD STREET 11TH FL
 COLUMBUS, OH 43215-3430

Account Number

Patient Name

Address

City State Zip

Date Mailed: _____

Unless currently hospitalized, please include a copy of your most recent Federal Tax Form 1040 & W-2's when you return this form.

Please complete and return this form in the pre-addressed envelope **no later than ninety (90) days** from the patient's date of admission. This form must be signed and completed by patient, spouse, or patient's legal guardian.

Patient's Phone Number	Name of the Patient's Spouse
Patient's Social Security Number	Spouse's Social Security Number
Patient's Date of Birth	Spouse's Date of Birth
Patient's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	If divorced, please give the Date of Divorce

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

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)

Employment

Patient's Employment Status <input type="checkbox"/> Currently working <input type="checkbox"/> Unemployed If Unemployed, Final Date of Employment _____	Spouse's Employment Status <input type="checkbox"/> Currently working <input type="checkbox"/> Unemployed If Unemployed, Final Date of Employment _____
Name and Mailing Address of Patient's Employer	Name and Mailing Address for Spouse's Employer
Patient's Occupation	Spouse's Occupation
Patient's Adjusted Gross Income Last Year	Spouse's Adjusted Gross Income Last Year
Does the patient or spouse have any other income? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain and indicate amount of income:	

Insurance (Hospitalization) - Private Policies, Employer Group and Union Group Health Insurance.

Policy covering patient issued in the name of:	Relationship of the Insured to the patient:
Group Number:	Certificate Number:
Type of policy: <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Union	
Name(s) and Address(es) of Insurance Company(ies):	

Sources of Other Income - do not list alimony, child support, General Relief (Welfare) or food stamps

Is the patient a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", Patient's VA Claim Number	Patient's Military Service Serial Number
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Source	Monthly Amount	Paid To: Patient, Spouse, or Guardian	Address If patient is not the payee give address of payee.
Soc. Sec. (blue check)			
S.S.I. (gold check)			
VA Pension			
Other			

List all of patient's or spouse's bank accounts owned individually, jointly, or in trust.

Name(s) on the account	Bank Name & Address	Current Balance	Type of Account

Other assets – Stocks, bonds, IRAs – if additional space is needed, please attach information.

Account Number	Name & Address where account is held	Current Balance	Type of Account

List below any real estate owned individually or jointly by patient. If additional space is needed, please attach information.

How Titled	Address	Primary Residence	Current Market Value	Current Mortgage Balance
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependents - list all dependents that the patient claims as a dependent on his/her Federal Income Tax 1040. If patient has more than four dependents, please attach a separate sheet with the additional information.

Name	Address	Date Of Birth	Relationship

Additional Dependent Information - Check any of the following for whom you may claim a deduction as an additional dependency.

<input type="checkbox"/> Patient is legally blind or deaf	<input type="checkbox"/> Spouse is legally blind or deaf
<input type="checkbox"/> Patient is 65 years of age or older	<input type="checkbox"/> Spouse is 65 years of age or older

Guardianship

Does the patient have a court appointed guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		Guardianship Number
Guardian of: <input type="checkbox"/> Estate <input type="checkbox"/> Person <input type="checkbox"/> Both		
Name of Guardian	Address	
Date of Appointment	By Probate Court of	

Life Insurance and/or Prepaid Funeral Expenses

Does the patient have life insurance and/or Prepaid Funeral Expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" complete the following:	
Name and Address of Life Insurance Company:	Face Value of Insurance:
Policy Number	Name and Address of Beneficiary:
If Prepaid Funeral Expenses, Name and Address of 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 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
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