Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Adult Care Facility (ACF)/Adult Foster Home (AFoH) Home Operator Incentive Form

Please complete information below verifying all residents linked with Mental Health (MH) and/or Substance Use Disorder (SUD) services on the last day of the Quarterly Reporting Period (see quarterly due dates noted below).	**OAKS Vendor #: (i.e., 0000299777)** 0 0 0 0 _ _ _ _ _ _

ACF or AFoH Information

You may submit one form per facility per quarter

ACF/AFoH Name	Operator Name	ACF/AFoH Address

License Type	Facility License #	Facility Contact #	Facility Contact Email	ACF/AFoH County
◯ Foster Home (1 - 2) ◯ Family Home (3 - 5) ◯ Group Home (6 - 16)	(i.e., 09-3377)			

Please **mark** the box for the quarter you are requesting participation:

Quarterly Reporting Period(s)	Total # of Licensed Beds	# of Residents linked on last day of Quarter
◯ **1st Quarter** (Jul. 1 - Sept. 30, 2014)		
◯ **2nd Quarter** (Oct. 1 - Dec. 31, 2014)		
◯ **3rd Quarter** (Jan. 1 - Mar. 31, 2015)		
◯ **4th Quarter** (Apr. 1 - Jun. 30, 2015)		

NOTE: For ***New*** Incentive recipient(s): If the payment mailing address submitted to Ohio Shared Services (OSS) to obtain your OAKS Vendor ID # is different than the facility address noted above, please indicate below the address you would like your check to go to (this address **must** match the address you stated on OSS **Vendor Information Form, Section 3 - "Remit To Address Required"** even if you are requesting a EFT (Direct Deposit Payment) - (**"new"** means you do not have a vendor # and/or did not participate in FY2013-2014 funding):

Street Address: City: Zip Code:

By voluntarily signing this form, you affirm that all residents included in the quarterly count(s) are currently residing in this facility on the end date(s) of the quarter(s) you are requesting funding participation. I hereby declare, certify and affirm that the information I have provided on this application, including all attachments and supporting documentation, is true and accurate to the best of my knowledge and belief. I further affirm that this agreement is voluntary and is entered into in good faith; therefore, any misleading or fraudulent activities will forfeit my ability to receive additional funding.

X _____ X _____

PRINT - ACF/AFoH Home Authorized Name - PRINT **ACF/AFoH Home Authorized (Signature)** **Date**

The quarterly form may not be signed, dated or submitted prior to the end date of each quarter.

This form may be emailed to OhioMHAS's Housing Policy and Resource Administrator at ACF-AFoHIncentive@mha.ohio.gov or sent via fax at 614-485-9747