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

I. Please complete information below for the selected Quarterly Reporting Period. Information should be as of *the last day of the Quarterly Reporting Period* specified, i.e., September 30th, December 31st, March 31st, or June 30th.				Quarterly Reporting Period
ACF or AFoH Information				
ACF/AFoH Name:	Operator Name(s):	License #:	License Type:	ACF/AFoH Address:
Operator Phone: Fax:	Operator Email:	ACF/AFoH County:	Total # of Licensed Beds	# of Linked Residents on *last day of Quarterly Reporting Period*

II. Please review the types of Mental Health and Alcohol & other Drug (AOD) services and their descriptions *prior to completing the next section*. All listed services must be provided by the local Mental Health and/or AOD provider agency.	
Type of Services	*Description of Services*
i. Case Management	i. Coordination of services & resources; includes Assertive Community Treatment (ACT), Community Psychiatric Supportive Treatment (CPST) and/or AOD
ii. Consumer-Operated Services (COS)	ii. Services, support, and education by peers
iii. Counseling/Psychotherapy	iii. Individual and group therapy services provided by licensed clinicians
iv. Diagnosis & Assessment	iv. Diagnosis completed by psychiatrist and/or mental health assessment
v. Health Home Services	v. Care management of physical & BH services at designated service sites
vi. Medication Management	vi. Prescription & medication monitoring for psychiatric diagnoses
vii. Medication-Assisted Treatment (MAT)	vii. Use of medications & counseling for AOD treatment
viii. Non-Medicaid Services	viii. Mental Health and/or AOD services provided that are not covered by Medicaid
ix. Partial Hospitalization/Day Treatment	ix. Community-based treatment services provided in structured setting

III. Please complete information below for all residents linked with Mental Health and/or AOD services on the *last day of the Quarterly Reporting Period* specified in Section I, i.e., September 30th, December 31st, March 31st, or June 30th. Up to 16 residents may be listed per Quarterly Reporting Period.

Resident Information

	Resident # 1	Resident # 2	Resident # 3	Resident # 4
Resident Name (Last, First)				
SSN				
DOB				
Medicaid ID (optional)				
Dates of Residence (please end with today's date if current resident)	to	to	to	to
Name of Local Service Provider(s)	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider
Service(s) Utilized ***Please mark all that apply.***	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization
Enrolled in Residential State Supplement (RSS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Resident # 5	Resident # 6	Resident # 7	Resident # 8
Resident Name (Last, First)				
SSN				
DOB				
Medicaid ID (optional)				
Dates of Residence (please end with today's date if current resident)	to	to	to	to
Name of Local Service Provider(s)	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider
Service(s) Utilized ***Please mark all that apply.***	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization
Enrolled in Residential State Supplement (RSS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

III. Please complete information below for all residents linked with Mental Health and/or AOD services on the *last day of the Quarterly Reporting Period* specified in Section I, i.e., September 30th, December 31st, March 31st, or June 30th. Up to 16 residents may be listed per Quarterly Reporting Period.

Resident Information

	Resident # 9	Resident # 10	Resident # 11	Resident # 12
Resident Name (Last, First)				
SSN				
DOB				
Medicaid ID (optional)				
Dates of Residence (please end with today's date if current resident)	to	to	to	to
Name of Local Service Provider(s)	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider
Service(s) Utilized ***Please mark all that apply.***	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization
Enrolled in Residential State Supplement (RSS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Resident # 13	Resident # 14	Resident # 15	Resident # 16
Resident Name (Last, First)				
SSN				
DOB				
Medicaid ID (optional)				
Dates of Residence (please end with today's date if current resident)	to	to	to	to
Name of Local Service Provider(s)	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider	☐ New Referral ☐ Existing Provider ☐ New Referral ☐ Existing Provider
Service(s) Utilized ***Please mark all that apply.***	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization	☐ Case Management ☐ COS ☐ Counseling/Psychotherapy ☐ Diagnosis & Assessment ☐ Health Home Services ☐ Medication Mgmt ☐ MAT ☐ Non-Medicaid Services ☐ Partial Hospitalization
Enrolled in Residential State Supplement (RSS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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.

ACF/AFoH Operator's Full Name	*Date*

1. **Please submit the following forms *quarterly* to OhioMHAS via email ACF-AFoHIncentive@mha.ohio.gov or fax (614) 485-9747:**
   - **ACF/AFoH Incentive Verification Form**
   - **Authorization for Release of Information (for AFoH residents only)**

2. **Please submit the following forms *one time only* to Ohio Shared Services (OSS) via email vendor@ohio.gov or fax (614) 485-1039:**
   - **W-9**
   - **Vendor Information Form**
   - **Authorization Agreement for Direct Deposit of EFT Payments**
   - **Voided Check or Deposit Slip**