Department of State Hospitals
1215 O Street, MS-3
Sacramento, California 95814
DSH 10268 (12/2022)

Financial Assistance Program Application

Please return to:
Department of State Hospital
Attn: Patient Cost Recovery Section
1215 O Street, MS-3
Sacramento, CA 95814
Email Address: DSHSacTrustOffice@dsh.ca.gov

Instructions: Please complete Sections A – E to the best of your ability. Supporting documentation may be attached to the application and sent along with the application to the address listed above.

Section A

Patient Information				
Patient First Name	Middle Name	Last Name		Date of Birth
Primary Address		City	State	Zip Code
Secondary Address		City	State	Zip Code
Check the following if they apply and if so; provide additional information below:				
☐ Guardian/Conservator	☐ Representative Payee			☐ Power of Attorney
First Name	Last Name	Date of Appointment	Phone Number	Email
Mailing Address		City	State	Zip Code

Family Member Information	
Patient's Marital Status: ☐ Single ☐ Married	Number of Dependents:

Please list all members of your household and their relationship to you below:		
First Name	Last Name	Relationship
First Name	Last Name	Relationship
First Name	Last Name	Relationship

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Section B

Health Insurance Coverage			
Do you presently have Health Insurance?: ☐ Yes ☐ No			
If you answered checked the 'Yes' box, provide additional information below:			
Primary Insurance Company Name		Policy Holder	
Policy/Subscriber ID Number		Group Number	
Relationship to Policy Holder: ☐ Self	☐ Spouse	☐ Parent	☐ Other
If you have a second health insurance policy, provide the following information:			
Secondary Insurance Company Name		Policy Holder	
Policy/Subscriber ID Number		Group Number	
Relationship to Policy Holder: ☐ Self	☐ Spouse	☐ Parent	☐ Other

Section C

Income and Assets

Instructions: Please list monies received in the Monthly Amount Received column. If not applicable, please list as 'N/A'. Please include supporting documentation with the application when it is submitted. Non-countable income is protected from collections and payment towards debt so does not need to be reported. See Attachment 1 for additional types of non-countable income.)

Source	Monthly Amount Received
Employment Income	
Supplemental Security Income	
Disability Benefits	
Veteran's Benefits	
Railroad Retirement	
Support from Spouse, Parent or Dependents	
Taxable Retirement Benefit	
Rental Income	
Other (describe):	

Financial Accounts

Instructions: Please list any bank accounts you own and their value below. If additional space is needed use Section E to add additional bank account information.

Type of account: ☐ Checking ☐ Savings ☐ Other _____ Bank Name: Address: Account Number (Last 4 digits only): Current Balance:
Type of account: ☐ Checking ☐ Savings ☐ Other _____ Bank Name: Address: Account Number (Last 4 digits only): Current Balance: Are you the beneficiary of a Trust? ☐ Yes ☐ No (if yes, please provide trust name, type, and trustee contact information using Section E)

Miscellaneous Assets

Instructions: Please list any stocks, bonds, or cryptocurrency holdings you own and their value below. If additional space is needed use Section E.

Description	Value

Real Property

Instructions: Please list any real property you own. If additional space is needed use Section E. Please also indicate which property, if any, you are claiming as your primary residence.

Description/Address	Primary Residence (yes/no)

Section D

Monthly Living Expenses

Monthly living expenses cover: ☐ Only yourself ☐ Yourself and dependents.

Expense Type	Monthly Amount
Health Insurance Premiums (including dental and vision)	
Legal Obligations (Alimony, child support, etc.)	
Transportation (car payments, insurance, gas, public transportation fees, etc.)	
House Payments (mortgage, rent, home insurance, property taxes, etc.)	
Food, clothing, and other household supplies	
School or childcare expenses	
Utilities (gas, electricity, water, garbage, telephone, etc.)	
Other:	
Total Monthly Expenses	

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Section E

Additional Considerations
Instructions: Please list any additional information that you feel will be relevant to DSH's consideration of your application for financial assistance, including additional bank account or stock and bond information. If you need additional space, please list the information on a separate sheet of paper and attach to the application.

I certify the above information to be accurate and complete. I understand that the Department of State Hospitals (DSH) reserves the right to verify all information supplied and that I may be required to provide proof of the information I am providing. I agree to notify the DSH-SacramentoTrust Office at (916) 654-1501 or DSHSacTrustOffice@dsh.ca.gov of any change in my financialinformation within 10 days of the change.

I am the: ☐ Patient
☐ Patient's Representative (Relationship to Patient _____)

Print Name	Signature	Date	Email	Phone

Address	City	State	Zip