STATE OF CALIFORNIA

Financial Assistance Program

California Department of State Hospitals

Application Instructions

DSH 10268F (Rev. 04/2023) [ENG]

The Department of State Hospitals Financial Assistance Program application is made up of three pages. To complete the application, please follow the below instructions.

Section A: Patient and Family Member Information

Patient Information – Fill out the following fields: *Patient First Name, Middle Name (if applicable), Last Name, Date of Birth, Primary Address, City, State, and Zip Code*. If there is a secondary address, please include this as well.

If you are the Guardian, Conservator, Representative Payee, or Power of Attorney, please check the appropriate box and provide your contact information and date of appointment.

Family Member Information – Select whether the patient is Single or Married and notate the number of Dependents. Please list all members of the patient's household and their relationship to the patient in the following format: *First Name, Last Name, Relationship*.

Section B: Health Insurance Coverage

Please indicate either 'Yes' or 'No' on whether the patient has Health Insurance, Medi-Cal, or Medicare. If the patient has health insurance, please complete the following section by providing the name of the company, the policy holder's name, the policy/subscriber ID number, and the group number. Also, please indicate the nature of the patient's relationship to the policy holder.

Section C: Income and Assets, Financial Accounts, Miscellaneous Assets, and Real Property

Income and Assets - Please notate any monies received in this section. In the right-hand column, across from each source type, indicate the monthly amount received. If not applicable, list as 'N/A'. Please provide copies of your pay stub, rent receipts, bank statements, and any other supporting documentation with the application when it is submitted.

Financial Accounts - Indicate what type of financial account the patient has. Ex: *Checking, Savings, Other.* List the Bank Name, Address, Account Number, and current balance.

If you have a second account, please fill out the second account fields in the same format.

Miscellaneous Assets - Please list any stocks, bonds, or cryptocurrency assets you own and their values. If multiple stocks and/or bonds are owned, please list each individually on a separate sheet along with their respective values and submit with the completed application.

Real Property – Please list any real property owned. Also indicate which property, if any, is the primary residence.

Section D: Monthly Living Expenses

Please indicate whether monthly living expenses covers just the patient or the patient and dependents. In the right-hand column across from the expense types, list the monthly expense amounts. At the bottom of the column, write the total monthly expenses. Please provide copies of mortgage statements, rent receipts, utility bills, etc.

Section E: Additional Considerations

Please list any additional information that you feel will be relevant to DSH's consideration of your application for financial assistance. If you need additional space, please include information on a separate sheet of paper and attach to the application.

Signature Section: Information Release and Signature

It is important to read and understand the information in this section. By signing the application, the applicant agrees to DSH's terms and conditions. Applications received without Patient or Patient's Representative's signature will be considered incomplete.

Mail, email, or fax completed form to:

Department of State Hospitals
c/o Trust Office
1215 O Street, MS-3, Sacramento, CA
95814
Email:DSHSacTrustOffice@dsh.ca.gov
Phone: 916-654-1501
Fax: 916-651-8908

If you need assistance in completing your application, please contact our Customer Service Unit. Our Customer Service Unit is available Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.