Department of State Hospitals
1215 O Street, MS-3
Sacramento, California 95814
DSH 10268 (Rev. 07/2025)

Financial Assistance Program Application

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

Instructions: Please fill out Sections A – C to the best of your ability. Supporting documentation should be included with the application and sent to the address listed above.

Section A

Patient Information			
Patient First Name	Middle Name		Last Name
Address	City	State	Zip Code
Date of Birth	Phone number		Email
Check the following boxes if they apply and 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 (Note: Family members are not responsible for a patient's cost of care.)	
Patient's Marital Status: ☐ Single ☐ Married	Number of Dependents:

Section B

Public Benefits	
Please check all the apply. Checking 'Yes' to at least one benefit below and providing supporting documentation may automatically qualify you for full debt relief.	
I have Medi-Cal: ☐ Yes ☐ No I receive General Assistance: ☐ Yes ☐ No I receive CalFresh: ☐ Yes ☐ No I receive SNAP: ☐ Yes ☐ No	I receive Supplemental Security Ins: ☐ Yes ☐ No I receive CalWorks: ☐ Yes ☐ No I receive other public benefits: ☐ Yes ☐ No *(TANF, SSDI, Unemployment Insurance, etc.)* Other public benefit(s): _____

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Section C

Patient Attestation
Check the boxes below that apply to you: ☐ Income ☐ Bank Accounts ☐ Rent ☐ Assets ☐ Health Insurance ☐ I have none of the above.

If you have no income, bank accounts, rent, assets, or other health insurance, and you have at least one Public Benefit and the supporting documents, skip Sections D and E and go to Section F.

Section D

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 examples of non-countable income.)

Source	Monthly Amount Received
Employment Income	
Social Security Benefits	
Taxable Disability Income	
Support from Family	
Taxable Retirement Benefit	
Rental Income	
Other (describe):	

Financial Accounts

Instructions: Please list any bank accounts you own and their value below.

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.)

Miscellaneous Assets

Instructions: Please list any stocks, bonds, or cryptocurrency you own and their value below.

Description	Value

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Real Property	
Instructions: Please list any real property you own. Please also indicate which property, if any, you are claiming as your primary home.	
Address	**Primary Home (yes/no)**

Section E

Monthly Living Expenses	
Monthly living expenses cover: ☐ Only yourself ☐ Including dependents.	
Expense Type	**Monthly Amount**
Health Insurance costs (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	

Section F

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-Sacramento Trust Office at (916) 654-1501 or DSHSacTrustOffice@dsh.ca.gov of any changes to my financial information within 10 days of the change.

I am the: ☐ Patient
☐ Patient's Conservator of the Estate *(please provide a copy of the conservatorship document)*

Print Name	Signature	Date

Address	City	State	Zip

Note: If the patient wishes for DSH to communicate with a third-party who is not the guardian or conservator, the patient must complete the "Authorization for Release of Patient Information" form and send to DSH-Sacramento Trust Office.