

# COMMONWEALTH OF VIRGINIA

## DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

PATIENT'S NAME:	REG.NO.:
SOCIAL SECURITY NO.:	BIRTHDATE:

### INSURANCE INFORMATION

<input type="checkbox"/>	PATIENT DOES NOT HAVE MEDICAL INSURANCE COVERAGE
<input type="checkbox"/>	PATIENT HAS MEDICAL INSURANCE COVERAGE AS INDICATED BELOW

*Please provide information even though benefits may presently be exhausted at this time*

COMMERCIAL INSURANCE		
Insurance Company:		
Policy/Contract Number:		
Group Name and Number:		
Policyholder Name:		
Employer:		
Employer Telephone:		
Insurance Co. Address:		
Telephone No.:		
Other Information:		
MEDICAID		
Medicaid No.:	County/City:	
Effective Date (If known)		
CHAMPUS		
Sponsor's Name & Rank:		
Active   Retired   Deceased (Please circle)		
Sponsor's Address:		
Telephone No.:		
Patient I.D. Card No.:		
Effective Date:	Issue Date:	Expiration Date:

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NAME:
SOCIAL SECURITY NO.:

Has a Committee, Trustee or Guardian been appointed by the court to manage the patient's affairs? Yes ___ No ___	
Name of Person Appointed: _____	Address: _____
Date Appointed: _____	Court Where Appointed: _____
Name of Person with Custody: _____	

***Provide information below for parents:***

Name	Address	Age	Phone No.
Father:			
SSN:			
Mother:			
SSN:			

***List all persons who live in the same household as patient.***

Name	Relationship	Income	Dependent

FATHER IS CURRENTLY EMPLOYED AT:
ADDRESS:
TELEPHONE NO.:
MOTHER IS CURRENTLY EMPLOYED AT:
ADDRESS:
TELEPHONE NO.:

**IF PATIENT IS RECEIVING SOCIAL SECURITY DISABILITY OR SSI, LIST PAYEE OF BENEFIT:**

<b>BENEFIT PAYEE - NAME &amp; ADDRESS:</b>
CLAIM NO.:
AMT. OF BENEFIT:
SSN OF PAYEE:



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**PARENT'S ASSETS (Please list present value, if any)**

Checking Account/s	\$	Bonds	\$
Savings Account/s	\$	Interest in Estates	\$
Stocks	\$	Interest in Trusts	\$
IRAs	\$	CDs	\$

  

Name and address of bank(s) where accounts located:		TYPE OF ACCOUNT	OWNER NAME
NAME	ADDRESS		

**PARENT'S PERSONAL PROPERTY: Please list all vehicles, boats, mobile homes, motor homes motorcycles or other items subject to Virginia's Personal Property Taxes**

ITEM	VALUE	BALANCE OWED
		\$

**PARENT'S REAL ESTATE PROPERTY (directly owned or estate interest)**

Location: City/County:	Address:
Description:	Assessed Value:
Balance Owed:	
Other Property:	

*If you need additional space to provide any information, list on a separate sheet of paper and attach*

**COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES**

NAME: _____
SOCIAL SECURITY NO.: _____

**I CERTIFY THIS IS A TRUE STATEMENT OF THE PARENT'S FINANCIAL CIRCUMSTANCES TO THE BEST OF MY KNOWLEDGE AND BELIEF**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ONLY IF YOU ARE A PARENT OR GUARDIAN FOR THE PATIENT, SHOULD YOU SIGN THIS SECTION**

\*\*\*\*\*

I agree to pay the Department of Mental Health, Mental Retardation and Substance Abuse Services the sum of \$\_\_\_\_\_ PER DAY for the care, treatment and maintenance furnished the patient.

This agreement is subject to the approval of the department based upon a review of the financial information you furnish. It does not prohibit the department from collecting additional sums from any other sources (such as Medicaid, or insurance) that may be available. Payments from all sources shall not exceed the cost of providing services. Either party may request a re-evaluation any time there is a change in ability to pay or a change in authorized charges.

Payments on billing statements are due and payable in full each month unless special arrangements are made for monthly installment payments.

Payments will be from:   (1) My personal resources \_\_\_\_\_  
                                  (2) Patient's resources under my control \_\_\_\_\_

**I CERTIFY THIS IS A TRUE STATEMENT OF THE PATIENT'S FINANCIAL CIRCUMSTANCES TO THE BEST OF MY KNOWLEDGE AND BELIEF AND I AGREE TO PAY THE AMOUNT ENTERED ABOVE IF THIS OFFER IS ACCEPTED BY THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**\*\*THANK YOU FOR YOUR TIME AND ASSISTANCE\*\***

**PENALTY FOR FAILURE TO RETURN THIS FORM PROPERLY COMPLETED**

Section 37.1-118 of the Code of Virginia provides that the Department may collect from the addressee of this form a penalty of five dollars per week for each week in excess of a thirty day period that this form is not returned, properly completed.