



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

Please complete information below verifying all residents linked with Mental Health (MH) and/or Substance Use Disorder (SUD) services on the last day of the Quarterly Reporting Period (see quarterly due dates noted below).

OAKS Vendor #: (i.e., 0000299777)

0 0 0 0

### ACF or AFoH Information

**You may submit one form per facility per quarter**

**NOTE:** Payment is issued by the Office of Budget and Management, Ohio Shared Services (OSS). You must register with OSS and receive an OAKS Vendor Number in order to receive payment. Applications that do not have the OAKS Vendor Number will not be processed. More information can be found at <http://ohiosharedservices.ohio.gov/VendorsForms.aspx>.

ACF/AFoH Name		Operator Name		ACF/AFoH Address	
License Type	Facility License #	Facility Contact #	Facility Contact Email	ACF/AFoH County	
<input type="radio"/> Foster Home (1 - 2) <input type="radio"/> Family Home (3 - 5) <input type="radio"/> Group Home (6 - 16)	(i.e., 09-3377)				

Please **mark** the box for the quarter you are requesting participation:

Quarterly Reporting Period(s)	Total # of Licensed Beds	# of Residents linked on last day of Quarter
<input type="radio"/> <b>1st Quarter</b> (Jul. 1 - Sept. 30, 2014)		
<input type="radio"/> <b>2nd Quarter</b> (Oct. 1 - Dec. 31, 2014)		
<input type="radio"/> <b>3rd Quarter</b> (Jan. 1 - Mar. 31, 2015)		
<input type="radio"/> <b>4th Quarter</b> (Apr. 1 - Jun. 30, 2015)		

By voluntarily signing this form, you affirm that all residents included in the quarterly count(s) are currently residing in this facility on the end date(s) of the quarter(s) you are requesting funding participation. 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. I further affirm that this agreement is voluntary and is entered into in good faith; therefore, any misleading or fraudulent activities will forfeit my ability to receive additional funding.

**X**

PRINT - ACF/AFoH Home Authorized Name - PRINT

**X**

ACF/AFoH Home Authorized (Signature)

Date

**The quarterly form may not be signed, dated or submitted prior to the end date of each quarter.**

This form may be emailed to OhioMHAS's Housing Policy and Resource Administrator at [ACF-AFoHIncentive@mha.ohio.gov](mailto:ACF-AFoHIncentive@mha.ohio.gov) or sent via fax at 614-485-9747